

**IN THE UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

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UNIVERSITY LEGAL SERVICES,)	CIVIL ACTION
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INC. et al.,)	1:05-CV-00585 (JMF)
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Plaintiffs,)	
)	
v.)	
)	
DISTRICT OF COLUMBIA,)	
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Defendant.)	
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**PLAINTIFFS’ MOTION FOR PERMANENT
INJUNCTION AND DECLARATORY JUDGMENT**

NOW COME Plaintiffs University Legal Services, Inc. (“ULS”) and Plaintiffs A and B, and pursuant to Federal Rules of Civil Procedure 57, hereby move this Court to issue a permanent injunction as well as a declaratory judgment to remedy the inadequate treatment and conditions afforded to residents at St. Elizabeths Hospital (“St. Elizabeths” or “the Hospital”) in violation of their constitutional and statutory rights under the Fifth Amendment of the United States Constitution; Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131, et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794; D.C. Mental Health Consumers’ Rights Protection Act of 2001, D.C. Code Ann. § 7-1231.01 et seq.; and the D.C. Human Rights Act, D.C. Code Ann. § 2-1401 et seq.

The grounds for this motion are set forth fully in the accompanying Memorandum of Points and Authorities and exhibits appended thereto.

Plaintiffs request a trial to be set by the Court within the next 45 days. Plaintiffs reserve the right to challenge any evidence that Defendant seeks to introduce in response to this Motion that consists of information Defendant failed to produce during the discovery period in this action.

WHEREFORE, for the reasons set forth above and in the accompanying Memorandum, Plaintiffs respectfully request that this Motion be granted and that Plaintiffs be afforded all other and further relief that the law allows.

This 9th day of April, 2007.

Respectfully submitted,

/s/ Mary Nell Clark
Mary Nell Clark (DC 419732)
Robin Thorner (DC 485492)
Patrick Wojahn (DC 483705)

UNIVERSITY LEGAL SERVICES, INC.
220 I Street, NE, Suite 130
Washington, D.C. 20002
(202) 547-0198

/s/ Lauren Reeder
Richard A. Schneider (GA 629569)
Lauren Reeder (DC 494572)

KING & SPALDING LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006
(202) 737-0500

Attorneys for Plaintiffs

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**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT
OF PLAINTIFFS’ MOTION FOR PERMANENT
INJUNCTION AND DECLARATORY JUDGMENT**

NOW COME Plaintiffs University Legal Services, Inc. (“ULS”) and Plaintiffs A and B and submit this memorandum in support of their motion for permanent injunction and declaratory judgment. As set forth below, Defendant District of Columbia has failed to provide adequate individualized mental health treatment to the patients at St. Elizabeths Hospital (“St. Elizabeths” or “the Hospital”) since the initiation of this lawsuit, and the Hospital remains unsafe, unsanitary and understaffed. Plaintiffs seek to remedy the serious violations of law harming patients at St. Elizabeths.

This Court must issue a permanent injunction to remedy the safety, sanitation, staffing and treatment issues that cause irreparable deprivations of each patient’s rights. Specifically, Plaintiffs request a permanent injunction that requires Defendant to: (1) cease violating patients’

constitutional and statutory rights; (2) ameliorate serious safety and sanitation issues; (3) increase staffing and improve staff competency; (4) provide individualized, active psychiatric treatment; (5) ensure that individuals with mobility disabilities and cognitive disabilities are afforded their rights under Title II of the Americans with Disabilities Act (“ADA”) and Section 504 of the Rehabilitation Act (“Section 504”); and (6) protect patients’ statutory rights enumerated in the D.C. Human Rights Act (“DCHRA”) and the D.C. Mental Health Consumer Rights Protection Act (“DCMHCRPA”). Plaintiffs also seek a declaratory judgment that Defendant has violated and continues to violate patients’ constitutional and statutory rights.

I. Introduction

Despite Defendant’s repeated promises since 2004 that it is addressing the myriad problems at St. Elizabeths Hospital, patients there continue to face great risks to their safety, and Defendant continues to provide inadequate psychiatric and medical care in an environment that dehumanizes patients. Plaintiffs filed a motion for preliminary injunction in the spring of 2005 after, *inter alia*: (1) several patients had suffered significant injuries and death at the Hospital; (2) the Centers for Medicare and Medicaid Services (“CMS”) had found a number of serious deficiencies; and (3) DMH’s consultant, Richard Fields, M.D., found that five of seven areas for which Defendant sought review were inadequate.¹ The Court determined that the issues raised

¹During discovery, plaintiffs uncovered a draft report from the District’s consultant, Dr. Richard Fields, that if the District had disclosed it to the Court in the Summer of 2005, might have caused the Court to issue an injunction at that time rather than deferring the matter for the collection of further evidence. The background facts are as follows. In November 2004, ULS wrote to Defendant alleging that care and conditions at St. Elizabeths were not adequate and were thus unlawful. In response, DMH retained Dr. Richard Fields to evaluate the Hospital. Dr. Fields did an inspection in December 2004, and issued a report dated January 14, 2005 that was made available to plaintiffs. The report provided that various areas “needed considerable improvement”, but Dr. Fields did not use the legally significant phrase of “not adequate.” Plaintiffs filed suit two months later, alleging that conditions at the Hospital in fact were not adequate. Plaintiffs attached Dr. Fields’ report to the complaint. Unbeknownst to plaintiffs, Dr. Fields’ January 2005 report had been preceded by a draft report that had rated numerous aspects of the Hospital, including staffing and training, as “not adequate.” Ex. 11, Fields Depo. at 55:2-56:5. The District did not advise plaintiffs of these earlier findings. During a deposition of Dr. Fields in December 2006, plaintiffs uncovered the existence of the draft findings for the first time. Shockingly, Dr. Fields revealed that he had changed his initial ratings of “not adequate” into the less-damning phrase “needs considerable improvement” at the District’s request!

should be determined after an evidentiary hearing. Univ. Legal Serv., Inc. v. St. Elizabeth's Hosp., No. Civ. 105CV00585TFH, 2005 WL 3275915, at *7 (D.D.C. Jul. 22, 2005). Plaintiffs thus moved forward to complete comprehensive discovery, which spanned fourteen months, almost thirty depositions, and the production of thousands of pages of documents. Plaintiffs now place before the Court substantial evidence that warrants the issuance of a permanent injunction.²

Discovery has confirmed the accuracy and urgency of Plaintiffs' preliminary showing two years ago. Defendant has made only minimal progress at best, and has failed to create lasting, systemic solutions to the Hospital's longstanding deficiencies. Defendant's own experts agree that the Hospital does not provide active treatment, and that the facilities, which are in substandard condition, evidence disrespect for the patients. See infra at II.B., II.E., and II.G. As such there is a continuing risk of bodily and dignitary harm to patients.

For example, on January 9, 2007, a patient who was dually diagnosed with mental illness and a cognitive disability died after staff improperly restrained him. Defendant's own investigation into the death revealed a series of failures, including, inter alia, inadequate staff response to the emergency, deviations from the Hospital's seclusion and restraint policy, and inaccessible and insufficient medical equipment. See generally Ex. 738, Death Investigation of Consumer [Homicide Victim] and Quality Improvement Review. The D.C. medical examiner ruled the death a homicide. Ex. 739, 1/10/07 [Homicide Victim] Autopsy Report at 1.

Id. The District finally produced the draft for the first time in 2007 after Dr. Fields' deposition. Thus, when Plaintiffs appeared before this Court in June 2005 and argued that staffing and other issues at the Hospital were not adequate, the District was able to argue that conditions merely needed improvement. Neither Plaintiffs nor this Court was advised in the Summer of 2005 that Dr. Fields' draft report found five of the seven areas under review "not adequate." Id. at 74:12-75:5.

² Plaintiffs filed a Motion to Compel after Defendant failed to produce all relevant documents and to answer Plaintiffs' interrogatories fully. That motion is still pending. Nevertheless, the evidence that Defendant has produced overwhelmingly demonstrates Defendant's failure to provide adequate treatment in a safe environment. Discovery has closed. Defendant should not be permitted to present any evidence now that should have been produced in accordance with this Court's Scheduling Orders.

In November 2006, CMS conducted a recertification survey and found that the two special conditions of Medicaid participation for psychiatric hospitals – special medical records requirements and special staff requirements – were deficient. See generally Ex. 49, 11/8/06 CMS Report. The Hospital’s deficiencies were “determined to be of such a serious nature as to substantially limit the hospital’s capacity to provide adequate care.” Id. at 1. In his most recent report, DMH’s consultant, Dr. Fields, found “modest, but inconsistent improvement,” even with “major accommodations” to support the Hospital, leading to the conclusion that “the pace and level of improvement . . . is disappointing.” Ex. 34, 12/30/06 Fields Report at 1; see also Ex. 11, Fields Depo. at 87:15-88:21 (citing “chronic recurring problems”). The Hospital was not even able to achieve fifty percent of its own identified objectives. Ex. 34 at 4. Significantly, one of Dr. Field’s progress indicators was to decrease the incident rates of the Hospital’s most disruptive patients, but the Hospital experienced a 106% *increase* over the baseline established in June 2006 for patient-on-patient assaults, and a 19% *increase* over the baseline for patient-on-staff assaults. Id. at 6.

Notably, the Department of Justice (“DOJ”) has been investigating the Hospital since the spring of 2005. Strikingly, while the District was appearing before this Court in the summer of 2005 and arguing that the District was not violating patients rights at the Hospital, the DOJ at that very same time was inspecting the Hospital. The DOJ found that the Hospital was in fact violating the patients’ rights under federal and District law by understaffing, failing to have individualized treatment plans, failing to provide a sanitary environment and fundamentally failing to ensure patient safety:

St. E’s fails to provide its patients with a reasonably safe living environment. The facility too often subjects its patients to harm or risk of harm. St. Es patients are subjected to assaults and harm from elopements and suicides. St. Es patients are subjected to undue seclusion and restraints. Resolution of these concerns is hampered by an inadequate risk

management and quality assurance system, and inadequate investigations of abuse and neglect. Finally, St. Es patients suffer harm from an inadequate physical plant.

Ex. 39, 5/23/06 DOJ Findings at 3.

Sadly, that situation has not changed to the present day. Plaintiffs' expert, Dr. Scott Stiefel, visited the Hospital on two occasions and his report of present conditions matches the DOJ's findings. Defendant's experts try valiantly to come to the defense of the Hospital but even they cannot help observing the dire circumstances and conditions facing the residents of St. Elizabeths. The District's position that things may have been bad but they are getting better is both unsubstantiated and no defense. The overwhelming evidence shows that the District has violated and is violating the law, and only an injunction and declaratory judgment can ensure that chronic failures are not permitted to persist.

II. Statement of Facts³

A. St. Elizabeths Fails to Protect Patients from Harm

Defendant has failed to create and maintain an environment that protects patients from physical harm stemming from assaults and other injuries. The wards are a place of continual and unpredictable violence, creating an atmosphere of fear that is pervasive and prevents recovery. See, e.g., Ex. 2, Safety Chart at 31-38; Ex. 728, Decl. of Mother of Patient at 3-5. Patient-on-patient and patient-on-staff aggression occurs routinely. Ex. 9, Stiefel Report at 4-5, 8-9. In fact, assaults occur on a near-daily basis. See generally Ex. 732, Unusual Incident Reports. In 2005, according to Defendant's records, there were 121 assaults on staff and 211 assaults on other patients. Ex. 185, FY05 Performance Improvement Dept. UI Report. In 2006, the total number

³ Though the facts may be "written in the dry and bloodless language of 'the law' – statistics, acronyms of agencies and bureaucratic entities, . . . official governmental reports . . . let there be no forgetting the real people to whom this dry and bloodless language give voice", Salazar v. D.C., 954 F. Supp. 278, 281 (D. D.C. 1996), some of the most vulnerable among us. "Behind every 'fact' found herein is a human face and the reality of being [an individual with mental illness] in the richest nation on earth." Id.

of assaults on patients increased to 261, with 93 assaults on staff. Ex. 29, FY06 Performance Improvement Dept. UI Report; Ex. 181, 9/06 Risk Management Report at 1. The violence continues in FY 2007. In the first five months of the fiscal year, there were 69 reports⁴ of staff assaults and 187 reports involving patient assaults. See generally Ex. 732.

Although the Unusual Incidents (“UIs”) rarely describe in detail the extent of the resulting injuries to patients or staff, the little detail that is included is alarming.⁵ For example, on January 27, 2007, “Patient . . . was observed chocking [sic] the patient in question.” Ex. 732 at 16335. On February 3, 2007, a patient “was hit in the face while he was sleeping by peer . . . he sustained about a ½ inch laceration left side of his face in his jaw area.” Id. at 16399. On February 14, 2007, a patient “came around to wisper [sic] something into his ears. The next thing noted was that he swunged [sic] and rained a couple of blows on . . . which staggered her to the wall nearby before staff intervention.” Id. at 16445. On February 17, 2007, a patient “was hit in mouth on lower left side – some bleeding noted.” Id. at 16371.

Defendant has received numerous warnings – from multiple sources⁶ – about the unsafe conditions at the Hospital. As early as 2002, the Director of Psychiatric Services warned Defendant about the serious violence occurring at the Hospital, describing injuries psychiatrists had suffered during patient assaults. Ex. 324, 8/14/02 Memo Krause to Knisley at 1-3. Over the years, staff has continued to express concerns about safety at the Hospital. See, e.g., Ex. 273, 12/8/03 Decision Memo Malik to Dearing at 1 (Death and injury rates will increase if the

⁴ This may include multiple reports for the same incident.

⁵ DMH’s general counsel has said that the UIs are frequently inaccurate. Ex. 690, 7/17/04 Letter Sturtz to ULS at 1; see also Ex. 381, 5/13/04 E-mail Crew to Rollison et al. at 1; Ex. 190, 5/13/05 Summary of CMS Key Points at 1; Ex. 331, 6/29/06 E-mails Between Baron, Carpenter & Holland at 1-2.

⁶ The Washington Psychiatric Society, the Chief Judge of the DC Superior Court and the patients themselves have all expressed concerns to Defendant about safety at the Hospital. Ex. 550, 1/17/06 Letter WPS to Williams; Ex. 552, 3/22/06 Letter King to Hogan; Ex. 248, Performance Improvement Team #4 Patient Safety Questionnaire (11 of 26 patients worry about assaults/threats); Ex. 522, 12/18/06 Inpatient Satisfaction Survey (“43.6% of patients reported that they do *not agree* that they felt safe while they were in the Hospital.”) (emphasis in original).

Hospital does not hire psychiatrists immediately, and the Hospital risks losing CMS participation); Ex. 251, 1/26/04 Memo Malik to Holland at 2 (Acritical shortage of inpatient psychiatrists, nursing staff, and general medical officers for the last two years. . . [T]he hospital is experiencing an increased number of assaults and injuries to the patients and the staff. . . . The situation will get worse with each passing day resulting in serious health complications including deaths”); see also Ex. 2, Safety Chart at 31-38. In fact, Defendant admits that the Hospital staff has reported concerns about safety since 2005. Ex. 735, Defendant’s Response to Plaintiffs’ First Request for Admissions at 13.

Yet Defendant does not timely intervene to remedy aggressive behaviors. In fact, needed interventions may only occur after multiple incidents of aggression, serious injury or the passage of time.⁷ Ex. 9 at 17. The Hospital does not appear to have a process for recognizing patterns at the individual patient level, which is critical not only for risk assessment and prevention but also for development of effective treatment strategies. Ex. 9 at 9. While a few patients are identified for review because they are involved in three or more UIs, their behaviors are often only superficially addressed by adjusting medication. See generally Monthly SEH Risk Management Alert Reports, cited in Ex. 2, Safety Chart at 21-27. Although the risk manager collects and shares data with various hospital committees on a monthly basis, when recommendations are made, the committees seems to report little more than procedural issues related to completing UI reports. See generally Ex. 2, Safety Chart at 38-63; see also Ex. 209, 6/16/05 GMO/Psychiatry Minutes at 3.

Defendant rarely conducts any follow-up or analysis of serious incidents. See, e.g., Ex. 48, Romero DOJ Expert Report at 28-29 (no investigation following an incident in which no

⁷ Defendant has begun sending aggressive patients to jail after altercations with staff – an inappropriate response to patients’ behavior. Ex. 9 at 17; see also Ex. 2, Safety Chart at 13-14.

available machine to obtain pulse on patient sent to ER), 33 (no investigation or follow-up of rape investigation), 54 (no follow up or investigation of incident in which patient who had just attempted suicide and had one-to-one but was found in bathroom attempting to cut her wrists); Ex. 42, Ryan DOJ Expert Report at 53-54 (no follow up or investigation of suicide attempt by patient using a plastic bag and string placed inappropriately in 4-point restraints); see also Ex. 11 at 145:15-146:9. For example, when a patient died in November 2005 after being diagnosed with cancer seven months earlier, the Hospital resisted conducting a root cause analysis into his death, despite the fact that he had lost more than forty pounds, complained of weakness and the inability to swallow, been repeatedly hospitalized after falls and dizziness for hypotension and dehydration, was existing at times on less than 600 calories a day, and did not have an updated treatment plan. Ex. 661, 4/25/06 Memo Taylor to Crew at 2-3.

Serious incidents are not reported or investigated as Major Unusual Incidents (“MUI”).⁸ See, e.g., Ex. 732 at 15887 (“Consumer . . . standing over consumer pounding him about the face and head [with] closed fist” – incident not numbered as MUI), 16180 (patient sent to the ER for treatment to hand and skull after an assault – incident not numbered as MUI), 15382 (patient sent to the ER with “swollen and tenderness nose including fr. nostril & mouth. Abrasion [with] superficial laceration upper lips” – incident not numbered as MUI). The Hospital’s few investigations of UIs are superficial and consistently credit the veracity of staff over the patients. See, e.g., Ex. 2, Safety Chart at 6-12. Despite its mandate,⁹ DMH rarely investigates allegations of abuse and neglect at the Hospital. Defendant only produced one investigation that DMH

⁸ The DMH Office of Accountability is required to take additional steps whenever the Hospital reports an MUI, including to “ensure the [Hospital] completes a written follow-up report on the disposition” of the MUI “when all details about the incident are not provided.” Ex. 736, DMH Policy 480.1A.

⁹ The DMH Office of Accountability is required to investigate MUIs as necessary, including deaths, potential abuse or neglect by staff, a pattern of incidents that could escalate and lead to a serious outcome, and “any incident when answers to questions on serious issues related to the incident cannot be satisfactorily answered via phone/documents sent to OA, and as requested by senior District officials.” Ex. 736, DMH Policy 480.1A.

performed of any of the incidents that has occurred at the Hospital. Without follow-up and analysis, Defendant cannot and does not prevent dangerous recurrences. Thus patients and staff continue to live and work in fear.

In January 2005, DMH's consultant, Dr. Fields, warned that "without effective intervention/change serious adverse patient incidents will sporadically occur at rates consistent with the facility's recent history." Ex. 38, 1/14/05 Fields Report at 10. Unfortunately, he was right.

B. St. Elizabeths Fails to Provide Adequate Treatment

The Hospital does not provide active treatment to most patients. Even Defendant's own expert, Dr. Jeffery Grace, must admit as much. Ex. 22, DMH Expert Grace Report at 4; Ex. 26, Grace Depo. at 111:9-112:11; 187:4-19; 188:2-9. For eight of the ten patients reviewed by Dr. Grace in October 2006 on the civil side of the Hospital, only twenty percent (20%) were actually receiving active treatment. Ex. 26 at 111:9-112:11. In January 2007, only half were receiving active treatment.¹⁰ Ex. 26 at 118:8-119:6. Similarly, CMS found in November 2006 that Defendant "failed to provide a therapeutic activities program appropriate to the needs and interests of patients that was directed to restoring and maintaining patients' optimal levels of physical and psychosocial functioning." Ex. 49 at 33. Defendant's failure to provide active treatment goes hand-in-hand with its failure to provide adequate and timely psychiatric and psychological assessments. Such assessments are critical to determine patients' diagnosis, assess for risk factors such as suicidality, and analyze treatment response over time. See, e.g., Ex. 5, Mental Health Treatment Chart at 1-8; Ex. 9 at 13, 17; Ex. 47, El-Sabaawi DOJ Expert Report at 6, 10-12; Ex. 471, 9/7/06 Psychiatry Minutes at 1 (psychiatrists are "50% compliant with

¹⁰ Dr. Grace attributes the improvement in the delivery of active treatment to the presence of one psychiatrist on the treatment mall, Dr. Vladar, who, in his estimation, provided more individualized therapy. Ex. 26 at 116:1-117:1.

Periodic Reviews”). Without adequate assessments, Defendant fails to provide properly individualized and targeted treatment interventions. Ex. 47 at 3-4.

Furthermore, patients do not receive care pursuant to individualized, multidisciplinary treatment plans, which is also essential to active patient care. Ex. 26 at 90:14-17; 152:9-153:14; Ex. 9 at 16-17; Ex. 25, Stiefel Depo. at 301:12-18; see also Ex. 25 at 304:18-22; Ex. 44, Bellack DOJ Expert Report at 9. The treatment teams at the Hospital seldom develop meaningful treatment goals and interventions that meet the standard of care, and do not collect data to assess the effectiveness of the treatment offered. Ex. 5, Mental Health Treatment Chart at 97-118 (re: Treatment Planning); Ex. 9 at 13, 17; Ex. 42 at 52 (indicating nursing staff does not adequately identify suicide risk); Ex. 44 at 2; Ex. 47 at 27, 42- 47; Ex. 49 at 30, 36. For example, after Plaintiff A, a patient with TBI, ran into a window hitting his head in January 2005, his subsequent treatment plans “fail[ed] to include needed behavioral interventions to address the ongoing risk.” Ex. 47 at 47; Ex. 721, 6/29/05-7/1/05 IRP at 1000003197, 1000003200; Ex. 722, 9/21/05 IRP Review at 1000003204; Ex. 723, 12/14/05 IRP at 1000003209. Although the psychologist’s role is to help with diagnostic clarification and the development of treatment goals and strategies, psychologists are not part of the Hospital’s treatment teams. Ex. 9 at 15; see also Ex. 25 at 281:1-2. “Adequate treatment planning requires adequate staffing of all necessary, relevant disciplines, and good communication between the members of the treatment team.” Plaintiffs’ expert found that “[n]either exists at St. Elizabeths.” Ex. 9 at 16; see also Ex. 47 at 37.

Moreover, Plaintiffs’ expert found that patients with severe behavior problems do not have behavior plans, and this has a “tremendous” impact on the patients’ care and contributes significantly to the risk of aggression. Ex. 9 at 14-15. When patients do have behavior plans,

they are not based on functional analyses of the patients' individual needs. Id.; see also Ex. 25 at 281:12-13.

Although the Hospital claims the treatment mall provides its active treatment, this treatment simply doesn't occur on a regular basis. The treatment mall has inadequate habilitative/rehabilitative resources. Ex. 9 at 11; Ex. 25 at 250:17-21. Recently, CMS found that Defendant failed to provide treatment at the treatment mall in an environment conducive to therapy, and with trained group leaders who are knowledgeable about the needs of individual patients. Ex. 49 at 14. Cancellations of group therapy sessions are common.¹¹ And often professional facilitators of groups are replaced by nursing assistants. Ex. 26 at 116:1-117:1. Activities at the treatment mall are not individualized and coordinated with patients' treatment plans.¹² Even the Geri-Mall, for elderly patients on the CMS-certified wards, utilizes a "one size fits all" approach that is not individualized. Ex. 42 at 62.

Defendant offers few alternatives to patients who do not attend the treatment mall. Ex. 26 at 122:8-21; Ex. 9 at 11. The wards lack sufficient activities, and scheduled group sessions on the wards often do not occur. Ex. 9 at 11; Ex. 38 at 13-14; Ex. 41 at 6; Ex. 400, 11/17/05 Report on Active Treatment for Patients Not Attending Treatment Mall; Ex. 49 at 18; Ex. 729, Valente Decl. at ¶¶ 21-23; Ex. 730, Allen Decl. at ¶¶ 8, 12. Moreover, therapeutic activities rarely occur on the weekends. Ex. 22 at 1, 4; Ex. 26 at 182:14-183:3.

In the absence of active treatment and behavior management, Defendant relies heavily on medication, often without long-term benefits. Ex. 47 at 27; Ex. 26 at 187:4-19; Ex. 9 at 13, 15, 18. When a high-risk patient is referred to the Clinical Consultation Support Team ("CCST") for

¹¹ Ex. 9 at 11; Ex. 41, 3/2/06 Fields Report at 6; Ex. 34 at 8; Ex. 49 at 20; see generally Ex. 5, Mental Health Treatment Chart at 38-46, 50-60, 63-70, 76-78.

¹² Id. at 159:9-153:14; Ex. 24, Steury Depo. at 123:21-125:10; Ex. 11 at 123:1-21; Ex. 42 at 2; Ex. 44 at 3; Ex. 38 at 3, 33-34; Ex. 403, 4/13/06-5/4/06 E-mails between Walsh, Richardson et al. at 1, 3.

additional treatment suggestions, any recommendation tends to be limited to medication changes. See, e.g., Ex. 359, CCST Referral; Ex. 17, CCST Referral; Ex. 360, CCST Referral; Ex. 361, CCST Referral. This is especially concerning given that there is often a mismatch between diagnosis and treatment. Ex. 47 at 5; Ex. 9 at 13; Ex. 35, 9/13/05 Fields Report at 6-7; Ex. 41 at 3. This excessive use of medication can have serious consequences for patients. See section C.2. infra.

Moreover, Defendant over-relies on the simultaneous use of multiple medications of the same class – polypharmacy – often without any documentation of medical decision-making. Ex. 9 at 13-15, 18. Polypharmacy has resulted in serious harm to the patients. See, e.g., Ex. 135, 2/8/06 P&T Minutes at 2 (“[patient] was sent to the ER on 1/17/06. He was on Risperdal . . . and Depakote He developed diabetes secondary to the antipsychotics”); Ex. 136, P&T Minutes at 2 (“Patient experienced severe blood pressure drop (71/41) after receiving Zyprexa Zydis, Klonopin and Depakote within a few hours after receiving Geodon. This patient was sent to Greater Southeast.” Another patient “had increased [uncontrolled movements] and complained about drooling.” He was taking Zyprexa and Haldol.); see generally Ex. 4, Medical Care Chart at 79-90.

C. St. Elizabeths Lacks Sufficient Numbers of Adequately Trained and Qualified Staff

Staffing is one of the Hospital’s “chronic recurring problems.” Ex. 11 at 88:20-21. As a result of inadequate staffing and insufficient training, Plaintiffs’ expert found that both patients and staff are unsafe at the Hospital. Ex. 9 at 22. Moreover, the Hospital’s staffing deficiencies directly impact the provision of adequate care and treatment.

1. Staffing Numbers

Maintenance of sufficient staffing levels is essential to preserve patients' health and safety, avert incidents of violence, and protect patients. Nevertheless, across all of the clinical disciplines, the Hospital lacks sufficient numbers of staff. This problem is chronic in nature, and directly compromises patient safety. Ex. 11 at 175:21-176:2; 259:20-260:6. Dating from 2002, the shortage of psychiatrists, registered nurses and general medical officers has often reached critical levels. See, e.g., Ex. 3, Staffing Chart at 15-104; Ex. 9 at 3-4.

Defendant needs to hire immediately an additional sixteen to twenty attending psychiatrists to provide an adequate level of psychiatric care. Ex. 9 at 6, 12; Ex. 362, SEH Staffing Plan at 2; see also Ex. 25 at 76:21-77:1. Due to the current understaffing, psychiatrists must cover multiple wards and carry inappropriately high caseloads, which compromises treatment. Ex. 9 at 4; Ex. 25 at 105:6-12; Ex. 47 at 7-8. Insufficient psychiatry coverage also adversely impacts physicians' attendance at continuing medical education, limiting their ability to provide up-to-date treatment. Ex. 9 at 12; Ex. 25 at 105:6-12.

The Hospital also lacks an adequate number of general medical officers ("GMOs") to provide general medical care. Ex. 3, Staffing Chart at 33-38. Defendant admits that the forensic patient population includes geriatric patients with chronic medical conditions. Ex. 735 at 6; see also Ex. 4, Medical Care Chart at 92 (eighty percent of the patients are elderly). Defendant's own Hospital Staffing Plan reveals that the Hospital needs at least six additional physicians for these positions. Ex. 362 at 1; Ex. 9 at 16.

The Hospital has a shortage of psychologists. Ex. 22 at 6-7; Ex. 3, Staffing Chart at 96-102. Only three or four psychologists provide direct care for the more than 400 patients at the Hospital. Ex. 39 at 20; Ex. 13, Gore Depo. at 224:11-22; Ex. 9 at 4, 14. The only psychologist with behavioral management experience, which is essential at a psychiatric hospital, has

significant administrative duties that detract from her clinical work, and the sole neuropsychologist – who works part-time – cannot meet the patients’ needs. Ex. 39 at 20; Ex. 32, Washington Depo. at 161:14-162:19; Ex. 9 at 4, 15; Ex. 5, Mental Health Treatment Chart at 8-29; see also Ex. 26 at 293:6-19. According to Plaintiffs’ expert, to achieve a 1- to-25 psychologist-to-patient ratio, in accordance with community standards, Defendant must hire an additional *twenty* psychologists. Ex. 9 at 6, 14; see also Ex. 362 at 2-3; Ex. 39 at 21.

Dr. Stiefel found that the Hospital is “grossly and dangerously understaffed with line nurses of all levels of training.” Ex. 9 at 24. St. Elizabeths must hire approximately sixty to seventy registered nurses (“RNs”), as well as other direct care nursing staff, to provide an adequate level of nursing care. Ex. 9 at 4, 6; Ex. 24 at 45:19-46:19; Ex. 26 at 111:9-112:11. Defendant’s own expert explained that having one RN per ward per shift describes the “comprehensive level of care that is needed by a professional nurse on the ward, including active treatment , individualize[d] assessments, interventions, discharge, the sort of processes that a nurse has to do. And the nurse is the principal person taking care of 24 patients during the eight hours that they’re assigned to that time.” Ex. 26 at 103:7-14. However, Dr. Grace found during his visits that forty (40) percent of the wards did not even have one RN per shift; consequently, non-licensed nursing staff were administering medications,¹³ and patients were not receiving adequate treatment. Ex. 22 at 4, Ex. 26 at 103:3-105:8, 255:10-21. Defendant’s own staffing schedules and sign-in sheets confirm that the Hospital regularly does not have an RN staffed on each ward on each shift. See Ex.3, Staffing Chart at 66-84. Moreover, Defendant regularly does not meet its own minimum ratios for other direct care staff. Ex. 33, 2/06 Dept. of Nursing Staffing Standards; Ex. 3, Staffing Chart at 66-84; Ex. 729 at ¶¶ 5-6. Defendant admits that it

¹³ See infra next section for discussion of medication errors and adverse drug reactions.

has a shortage of nursing staff that requires the use of overtime hours and contract nurses. Ex. 735 at 5.

Defendant also does not have sufficient numbers of rehabilitation services staff to provide individualized, active treatment to patients. Ex. 3, Staffing Chart at 102-103; Ex. 9 at 4-5. As discussed above, many groups at the treatment mall have been cancelled due to insufficient staff. Ex. 5, Mental Health Treatment Chart at 38-46, 50-60, 63-70, 76-78; Ex. 9 at 11; Ex. 25 at 259:7-12. Current staff is overwhelmed, Ex. 9 at 11, and patients suffer as a result.

The Hospital's understaffing has far-reaching consequences: patient-on-patient and patient-on-staff aggression occurs routinely, see supra at II.A., and patients do not receive adequate psychiatric or medical treatment, Ex. 25 at 272:6-8. See also Ex. 26 at 116:1-117:1, 152:9-153:14, 261:16-262:14. The nursing shortage also contributes to an unsafe and hazardous environment. Ex. 20, Shorr Report at 8. Members of the Hospital staff regularly express concern about the impact that the lack of staffing has on both patient and staff safety. Ex. 3, Staffing Chart at 15-104. And Defendant admits that patients have missed medical appointments off campus due to the unavailability of staff to escort the patients. Ex. 735 at 11-12; see also Ex. 41 at 12; Ex. 4, Medical Care Chart at 90-91.

The Hospital also fails to adequately recruit or retain qualified staff. Plaintiffs' expert found that the current environment at the Hospital renders acquisition and retention of competent staff "impossible." Ex. 9 at 21. Staff members report that Defendant has not done what is necessary to recruit and retain competent staff. Id. at 8. The Hospital's pay scale and the dangerous conditions have often been barriers to staff recruitment. Ex. 3, Staffing Chart at 104-108.

As a result of the Hospital's history of violence and understaffing, most staff are afraid of the patients, which negatively impacts the staff's interaction with them. Ex. 9 at 4-5; Ex. 19, McKinley Depo. at 161:20-163:13. Defendant's consultant has warned that concerns about personal safety can be expected to affect staff morale and possibly the quality and appropriateness of patient care. Ex. 41 at 17.

2. Staff Ineffectiveness and Mistakes

While a competent staff is absolutely critical to adequate treatment and care, patients suffer because of staff mistakes and failures – many of which might not have occurred had there been adequate staff. The DOJ investigation revealed numerous instances of questionable staff competence and a lack of knowledge about the fundamentals of patient care. See generally Ex. 47 at 6, 14; Ex. 44 at 14; Ex. 42 at 5, 9, 55. Plaintiffs' expert found that many staff members refuse to engage with the patients in meaningful ways, instead interacting with them disrespectfully, and often from behind the barrier of the nursing station. Ex. 9 at 6; Ex. 25 at 232:10-19; 280:12-18; see also Ex. 730 at ¶¶ 9-10. Even at John Howard Pavillion ("JHP"), where the staff more consistently interacts with patients, the level of interaction is not sufficient for adequate patient care. Ex. 9 at 6.

a. Problems with Medical Treatment

Recognition and treatment of general medical co-morbidity is critical to treatment of patients with mental illnesses, yet Plaintiffs' expert found that the quality of medical care at St. Elizabeth suggests incompetence:

Many general medical problems are not identified or are only partially evaluated and treated, which has an adverse impact on patients' physical and mental health. The records contain numerous examples of inadequate medical care, such as unrecognized constipation, urinary incontinence that is not addressed, issues related to pain, including identification, workup and appropriate treatment, unrecognized and untreated gastro esophageal reflux, sleep disorders, and unrecognized and untreated infections.

Ex. 9 at 16. The DOJ Nursing Expert Report is replete with examples of nursing errors, including the failure to assess patients properly and the failure to take appropriate actions. See generally Ex. 4, Medical Care Chart at 34-39. Psychiatrists seem unaware of serious potential side effects of medications, and tests required to monitor their effects and critical lab work are often not performed. See Ex. 39 at 32; see generally Ex. 4, Medical Care Chart at 1-27, 40-50.

In addition, nursing staff fails to monitor medications and to recognize and address medication side effects, such as over-sedation and extrapyramidal symptoms – involuntary movements. Ex. 9 at 13; Ex. 25 at 155:18-156:1; 156:3-6; 159:21-160:8; 268:20-269:1. Standard tools for assessing medication side effects, such as the MOSES, are not utilized in a consistent manner to determine if patients are experiencing side effects. See Ex. 39 at 32; Ex. 47 at 6, 12-15, 18-19, 27. One-third of the approximately forty patients Plaintiffs’ expert examined “were experiencing significant side effects and drug-drug interactions that were impacting their quality of life and participation in treatment.” Ex. 9 at 13. Moreover, the DOJ Psychiatry Expert found that some psychiatrists have a tendency to change medications because of careless assessments or while covering for other psychiatrists, which has also resulted in harm to some patients. Ex. 47 at 7, 17.

Direct care staff rarely reports adverse drug reactions (“ADRs”) or medication errors. See generally Ex. 4, Medical Care Chart at 1-27, 54-76; Ex. 47 at 29 (“For a facility the size of SEH and with the complexity of medication regimens used for its individuals, one would expect [at least one ADR] for each unit. . .”). Staff acknowledges that they are afraid to make reports and so they cover up for each other. See Ex. 16, Jibril Depo. at 305:22-306:20; Ex. 467, 5/3/06 Quarterly Performance Improvement Committee Minutes at 2; Ex. 41 at 15; Ex. 655, Report to the Executive Staff from Chair of the PIC 2nd Quarter 2006 at 1. Given the medical staff’s

failure to recognize and/or report errors, pharmacists are essential to the Hospital to avert medication errors and preserve patient's safety, but in September 2006, the chief pharmacist announced he had lost 2 of his 5 pharmacists" Ex. 138 at 2. Then, in October 2006, he himself was removed because the DEA was investigating him. Ex. 22 at 5.¹⁴

Incidents described as "Miscellaneous Pharmacy Interventions" include serious medication errors and ADRs that are not counted as such. See, e.g., Ex. 140, 6/14/06 Pharmacy & Therapeutics Minutes at 4 ("On 5/24/06 psychiatrist started the patient on Risperdal . . . without titrating. . . patient collapsed and exhibited signs of Tardive dyskinesia. The pharmacist assisted along with other medical staff during the code Blue;") see generally Ex. 4, Medical Care Chart at 18. Those ADRs or medication errors that are recorded describe numerous instances when patients were subjected to potential and real harm. See generally Ex. 4, Medical Care Chart at 1-27, 54-76.

Death reviews are cursory and rarely question the adequacy of the medical treatment Defendant provided. None of the death reviews Defendant provided to its expert, Dr. Grace, included progress notes or analyzed whether the medical staff provided adequate medical treatment prior to the death.¹⁵ See generally Ex. 4, Medical Care Chart at 31-32.

Staff does not adequately address obesity, weight loss, and diabetes, which are serious patient medical concerns at the Hospital. Ex. 42 at 9, 46 - 47 (11 of 28 charts had unidentified significant change in weight); Ex. 44 at 8; Ex. 47 at 7-8, 10; see generally Ex. 4, Medical Care Chart at 32-34. One patient who recently died was 5'4" and weighed 280 pounds, but had no plan for weight reduction. Ex. 42 at 44. Patients' dramatic weight loss does not result in

¹⁴ Defendant has not produced any information regarding this significant development. Plaintiffs do not know whether, six months later, the pharmacist position has been filled.

¹⁵ Defendant refused to provide mortality review records to Plaintiffs in the course of discovery, but Defendant's expert provided Plaintiffs access to the limited number of death records he reviewed.

evaluations or dietary plans. Ex. 38 at 19. The patient discussed in section II.A. *supra* appears to have been starved to death. Ex. 661 at 2-3.

Sadly, as a result of staff's inattention, the DOJ Nursing Expert found that patients return to community hospitals again and again for dehydration. Ex. 42 at 4; Ex. 138, 9/12/06 Pharmacy & Therapeutics Minutes at 1.

b. Failure to Train

Staff training is critical to ensure patient health and safety. While the Hospital has a training program with a set of mandatory trainings, many staff members have not participated. As of January 19, 2007, many staff members, including the Director of Psychology and numerous RN's, had not taken the mandatory training within the past year.¹⁶ Ex. 3, Staffing Chart at 118-126. Furthermore, the Hospital does not undertake any systemic effort to measure whether staff retains the information presented in the trainings or uses this knowledge in their day-to-day practice. Ex. 42 at 1; Ex. 25 at 97:17-19; see also Ex. 49 at 18 ("the facility failed to provide adequate clinical leadership in medical, nursing and social work areas to direct, monitor and evaluate care to patients."). As a result, significant gaps in knowledge exist throughout the disciplines. Ex. 22 at 5; Ex. 47 at 6; Ex. 38 at 32-33; Ex. 25 at 89:22-90:3; see also Ex. 25 at 76:21-77:8.

Staff members report they are ill-equipped to supervise violent patients, despite their claim to be properly trained. Ex. 162, 10/5/05 Performance Improvement Committee Minutes at 3. Apart from initial orientation, Defendant provides few opportunities for meaningful staff training and continuing education opportunities. Ex. 9 at 7. Defendant's failure to provide sufficient staff trained to deal with serious medical problems and/or severe behavioral problems

¹⁶ Understaffing, principally, interferes with staff attendance at training sessions; this is particularly problematic for staff who work the night and weekend shifts. Ex. 9 at 7; Ex. 25 at 84:8-17.

consigns patients to unduly restrictive environments with “no reasonable expectation of change.” Ex. 44 at 5.

3. Overcrowding

The understaffing at the Hospital is made all the more dangerous in light of continued patient overcrowding. This places patients and staff at risk of serious harm due to increased tension. Staff regularly complains about overcrowding on the wards at the Hospital. Ex. 26 at 119:7-14; Ex. 201, 1/5/05 Psychiatry Minutes at 4; Ex. 38 at 15. Each ward is “designed to hold 23 beds,” but in 2006, the Hospital decided that each ward should have 25 beds. Ex. 379, 1/06 E-mails between Jibril and Carson at 1. Over the course of the third quarter of FY 2006,¹⁷ the census on the both the civil and forensic wards increased. Ex. 458, PI Dept. Statistical Analysis/Patient Demographic Report March 1, 2006-June 30, 2006 at 1, 6. From January 2006 through January 2007, there were 448 times that one of the forensic wards was recorded as being over census and 140 times that one of the civil wards was so recorded. See generally Ex. 733, Census Charts. At JHP, there was an immediate need for increased bed space and staffing in 2006. Ex. 552, 3/22/06 Letter King to Hogan at 1.

D. St. Elizabeths’ Continued Use of Seclusion & Restraint Jeopardizes Patients’ Liberty and Safety

Seclusion and restraint should be used only when a patient poses an imminent risk of serious injury to self or other. 22A DCMR §§ 500.6, 501.2. Nevertheless, staff at the Hospital routinely uses seclusion and restraint in violation of District law. Both D.C. law and the Hospital’s policy regarding use of seclusion and restraint strictly limit the situations when seclusion and restraint may be used and require specific documentation when it is. 22A DCMR §§ 500.1 et seq.; Ex. 737, SEH Policy 101-04. Many episodes of seclusion or physical restraint

¹⁷ Defendant has not produced any statistical analysis/patient demographic reports for any later periods.

could have been avoided if the treatment teams were functioning properly, staffing was adequate, staff had appropriate training in de-escalation techniques, and patients had adequate behavior intervention plans. Ex. 9 at 18. Simply treating patients in a caring and professional way would also result in a significant change.

Staff members regularly fail to take appropriate initial steps, such as non-violent de-escalation and examination by a psychiatrist, which are intended to ensure that seclusion and restraint is used only as a last resort, and that its use is discontinued as soon as possible. See, e.g., Ex. 34 at 16; Ex. 35 at 10; Ex. 38 at 19-20; Ex. 41 at 4, 13; Ex. 47 at 28. Staff members also fail to monitor the safe use of seclusion and restraint and to debrief following episodes of seclusion or restraint. See, e.g., Ex. 5, Mental Health Treatment Chart at 17-25 (listing patients for whom no post-S/R review documentation has been received); Ex. 18, 4/12/06 E-mails between Malik, Teter and Richardson; Ex. 34 at 16. In 2006, two external reviewers contracted by DMH as part of the formal grievance process found that staff failed to follow proper procedures in several seclusion and restraint episodes involving the same patient.¹⁸

Chemical restraint has also been used when clearly inappropriate. See, e.g., Ex. 732 at 1000029427 (after patient was making “threatening remarks” on the phone with the CEO’s office), 1000029684 (after patient was “pacing loudly and making remarks to unseen people”), 1000029709 (after patient was “push[ing] past a doctor while leaving unit”). Additionally, Dr.

¹⁸ The first external reviewer found that “absence of documentation regarding the patient’s behavior and affect make it difficult” to determine what happened in the chemical restraint episode involved, and recommended additional “training” and a “review procedure by staff” to examine compliance with the applicable protocols for use and documentation of seclusion and restraint. Ex. 555, 2/3/06 External Review Advisory Opinion at 6. In two opinions regarding two other incidents, the second external reviewer found that staff violated the seclusion and restraint policy by: “ordering emergency medication of [the patient] without a face-to-face assessment”; and “sign[ing] [the] order for emergency medication without examining [the patient].” She noted that both of these actions, although violations of policy and D.C. regulation, were “consistent with St. Elizabeths’ common practices,” and recommended training for “physicians and nurses” on chemical restraint guidelines. Ex. 557, 7/8/06 External Review Advisory Opinion at 6-7; Ex. 558, 5/27/06 External Review Advisory Opinion at 6-8.

Fields and the DOJ experts found inadequate documentation supporting the use of seclusion and restraint. Ex. 7, Seclusion and Restraint Chart at 1-4, 7-8, 11-12.

Training on proper use of seclusion and restraint is infrequent and inadequate. See generally Ex. 3, Staffing Chart at 119-123, 124-126; Ex. 484, SEH Civil Mandatory Compliance Data; Ex. 539; see also Ex. 21, Ratner Depo. at 132:2-15; Ex. 8, Banzon Depo. at 218:19-219:3, 266:1-3. For those who have received training, the Hospital does not ensure competency. Ex. 30, Vidoni-Clark Depo. at 107:15-108:3; Ex. 27, Teter Depo. at 197:3-5.

The most tragic example of Defendant's failure to properly train and monitor the staff on seclusion and restraint occurred on January 9, 2007, when a patient died as a result of a staff person's inappropriate use of restraints. The staff person involved had received seclusion and restraint training on December 21, 2006. Ex. 539, 1/19/07 SEH Civil Mandatory Compliance Data at 3. Nevertheless, he demonstrated a gross violation of proper practice when he attempted to restrain the patient. See generally Ex. 738, Death Investigation. Numerous staff witnesses reported that the staff person was on top of the patient before he died of asphyxiation, and some reported that staff had placed the patient in a prone position. Id. at 2-6.

The Hospital claims in reports that seclusion and physical restraint use has experienced an overall decline in the last two years. But seclusion and restraint remains at an unacceptable level. Ex. 9 at 18. Even using the Hospital's own numbers, from April through September 2006, the incidence of restraint use increased ninety-nine percent (99%). Ex. 34 at 15.

Furthermore, the numbers in the Hospital's reports are simply wrong. Although the over-use of PRNs and emergency medication is a significant problem at the Hospital, Ex. 7, Seclusion and Restraint Chart at 12-14, this use of chemical restraints is not comprehensively tracked. Ex. 28, Thomas Depo. at 204:8-205:5; Ex. 30 at 162:16-166:22; Ex. 27 at 242:3-9; Ex. 41 at 14.

Although the Performance Improvement Department tracks PRN incidents reported in the UIs, Ex. 449 at 6, seclusion and restraint (including chemical restraint) is not reported as an unusual incident unless the patient is injured. Ex. 153, 7/17/05 Risk Management Committee Minutes at 1.

In addition, seclusion and physical restraint happens but is not labeled and reported as such. Ex. 9 at 18-19; Ex. 25 at 124:19-22; 126:22-127:2; 226:2-6; 237:1-6. The Hospital changed its definition of physical restraint in FY 2006 so that the numbers dropped precipitously.¹⁹ Moreover, Plaintiffs' review of the records reveals at least eighty-five (85) incidents of seclusion and/or restraint (not including chemical restraint and protective measures) in FY 2006 that were not reflected in the Hospital's official statistics. Ex. 7, Seclusion and Restraint Chart at 38-77. This underreporting prevents the Hospital from assessing the appropriateness of the seclusion or restraint and developing opportunities for best practice going forward.

Finally, patients are sometimes placed in a mysterious "suite" located in the John Howard Pavilion ("JHP") as a form of seclusion. Ex. 23, Smith Depo. at 305:14-306:6. This "suite" is for "particularly dangerous and disruptive patients." Ex. 21 at 132:19-133:12. Defendant has provided no documentation about when this suite is used or what specifically it is used for, and it does not appear that time spent in the suite appears in any of the Hospital's seclusion and restraint data.

E. St. Elizabeths is Unsanitary and Unsafe

¹⁹ Under the old seclusion and restraint policy, soft restraints and protective measures such as side rails were included in the statistics as restraints. Due to a change in "understanding," soft restraints and protective measures are no longer considered restraints under the policy, thus the statistics do not include them. Ex. 30 at 189; 14-191:15. Patients in soft restraints accounted for a large number of restraint hours before the change in "understanding." Ex. 112, Seclusion & Restraint by Location: Forensic May-December 2005.

Defendant's management expert, Arthur Shorr, acknowledges that environmental and structural issues "have direct and immediate impact upon day-to-day and month-to-month care of St. Elizabeths patients." Ex. 20 at 13. Defendant has failed to provide necessary repairs and upkeep over the years, such that even DMH's expert recognizes the Hospital's physical plant is "in substantial generalized disrepair," and patients must live in an environment that is not conducive to recovery. Ex. 22 at 4; see also Ex. 31, Warsh Depo. at 42: 13-17; 63:10-64:1; Ex. 46, 1/12/07 Dixon Court Monitor Status Report at 15. Mr. Shorr found that the wards where patients live are "clearly in need of total replacement because they [are] beyond their functional or even extended useful life." Ex. 20 at 9; see also Id. at 14. Despite the deteriorated physical plant, in FY 2007, Defendant did not approve capital budget expenditures of \$4.5 million for continued renovations and general improvements at the Hospital. Ex. 31 at 39:19-40:18.

For years CMS and Dr. Fields, and now the DOJ experts, have described a hospital that is unsafe and impedes treatment. See generally Citations to CMS, Romero, Ryan, and Fields Exhibits in Ex. 6, Unsanitary Chart. The Hospital's problems are extensive and include, inter alia:

- Unhealthy and unsafe conditions such as asbestos in the floors of JHP. Ex. 525, 7/24/06 E-mails between Taylor and Warsh at 1. Broken glass and exposed metal can be found on wards housing patients with a history of self-harm. Ex. 9 at 19; see also Ex. 48 at 54. The wards have long corridors where patients cannot be observed. Ex. 26 at 118:8-15; see also Ex. 6, Unsanitary Chart at 63-84.
- Infection Control is a serious problem. Although repeatedly criticized for staff's failure to test for tuberculosis, the Hospital's PPD compliance rate remains low. See generally Ex. 6, Unsanitary Chart at 58-61. The Hospital apparently gave up:

“Dr. Zaidi indicated Employee Health clinic is no longer offering PPD: in lie[u] a statement by the Primary Physician that employee or applicant is free of communicable/TB infection will suffice.” Ex. 481, 10/4/06 GMO Minutes at 1. Even though the Hospital had “17 positive cultures for MRSA since July 2006,”²⁰ it has not had an isolation area to protect other patients from this contagious infection.

- Fires are a major concern, as well as the Hospital’s failure to appropriately evacuate patients or follow up to ensure improved response. There were at least six fires on the wards between September 2005 and October 2006. See generally Ex.6, Unsanitary Chart at 41-43. In one incident, four patients simply walked away from the Hospital: “One patient was returned to the Hospital by the . . . police and there is no record of the other three patients. No one conducted a head count of the patients until the CEO requested.” Ex. 369, 4/25/06 Performance Improvement Dept. Minutes at 2.
- The temperature in the buildings is often too hot or too cold, leaving patients uncomfortable and more likely to react violently or fall ill. See generally, Ex. 6, Unsanitary Chart at 43-52. Between May and December 2005,²¹ the temperature on at least one ward fell below the recommended temperature 589 times, and was over 80 degrees 787 times (it was over 90 degrees 19 of those times). See generally Ex. 731, Temperature Chart.
- Defendant does not maintain sufficient ward supplies, such as toilet paper and paper towels, Ex. 26 at 119:7-14, and, as a result, staff brings these items from

²⁰ Ex. 483, 1st Quarter 2007 Dept. of Education Newsletter at 6.

²¹ Defendant produced no other temperature logs.

home, Ex. 9 at 20. Essential equipment is broken constantly. Washing machines and dryers repeatedly need repair. See generally Ex. 6, Unsanitary Chart at 4-40.

- Pests and rodents are a common problem on the wards. Ex. 9 at 19; see also Ex. 26 at 137:8-17. See generally Ex. 6, Unsanitary Chart at 61-63.
- Elevators are constantly out of service. See generally Ex. 6, Unsanitary Chart at 2-4. In JHP, the elevators doors “can be opened manually, on any floor, when the elevator car is not there.” Ex. 152, 4/20/05 Risk Management Minutes at 2. Patients “have begun showing hostility towards using the elevators and are not allowed to travel on elevators unaccompanied.” Ex. 226, 6/15/05 Risk Management Minutes at 2.

Defendant has “chronically underfunded” supplies and equipment essential to patient care, including, but not limited to, blood pressure cuffs and medication carts. Ex. 20 at 14. Inadequate funding for supplies, pest control, dietary needs and repairs negatively impact safety; the problems are so severe that money from different department budgets must be shared and stretched to meet basic needs. Ex. 41 at 21. Although Defendant was aware that critical medical equipment was either broken or not adequately maintained, Ex. 152 at 3, it did not act. Had the oxygen tanks functioned and been accessible, the death in January 2007 may have been prevented. See Ex. 738 at 1-5, 12.

Defendant’s psychiatry expert, Dr. Grace, acknowledges that the deteriorated physical environment of the Hospital has a direct impact on patient care. “[K]nowing the aesthetics of where you live contributes to your awareness of whether it’s safe and whether you feel clean or whether you feel less paranoid. So a therapeutic environment would be one that is, of course, clean It’s well lit and appropriate and quiet with furniture that you don’t have to fear that

you're going to hurt or harm yourself or is clean." Ex. 26 at 118:20-119:6; see also Ex. 694, 1/06 DMH Acting Director's City Council Testimony at 1 ("St. Elizabeths' patients continue to live and receive treatment in outdated buildings These buildings no longer meet our patients' needs for treatment nor do they provide a suitable living environment to promote recovery from mental illness.").

F. St. Elizabeths Fails to Accommodate Patients with Mobility Disabilities and Cognitive Disabilities

1. Patients with Mobility Disabilities

Defendant excludes patients with mobility disabilities from access to the full range of facilities, programs, and services offered to able-bodied patients. Defendant fails to accommodate patients with mobility disabilities as required by the ADA guidelines and best nursing practices. See, e.g., Ex. 555 at 2; Ex. 42 at 49. Defendant admits that it does not know how many patients at the Hospital use wheelchairs and other assistive devices and has not endeavored to study those patients' access to all facilities, programs, and services. Ex. 24 at 75:7-21. Staff acknowledges that the Hospital is not well suited to accommodate individuals who use wheelchairs. Ex. 555, 2/3/06 External Review Advisory Opinion at 2. Bathrooms on many of the wards and on the treatment mall are not accessible to patients with mobility disabilities, forcing patients to use the facilities without privacy and appropriate accommodations. Ex. 9 at 9-10; Ex. 25 at 132:22-133:8; see also Ex. 48 at 10.

For example, on one of the wards at JHP, the only accessible bathroom for a patient who uses a wheelchair is so small that he must keep the door open while he uses the toilet, Ex. 25 at 132:22-133:8, and on another ward, a male patient must use the toilet on the female wing of the ward, Ex. 9 at 9-10. Defendant's failure to provide accessible bathrooms places patients at risk

of great injury as they try to maneuver inadequate facilities. Ex. 9 at 9-10. Wheelchairs and other assistive devices provided by the Hospital are in poor condition. Id.; Ex. 25 at 131:6-19.

Patients who have physical limitations are not able to participate at the treatment mall for a number of reasons, including broken elevators and insufficient numbers of staff to assist with transportation, and are not provided alternative therapies. Ex. 9 at 10, 20; Ex. 25 at 143:15-20; 145:5-146:2; see also Ex. 26 at 304:20-305:10; Ex. 400 at 1-2; Ex. 729 at ¶ 20. The broken elevators also create safety concerns for patients with mobility disabilities. Ex. 9 at 20. During a recent fire drill, the Hospital did not follow its fire evacuation policy, but instead had patients, including a bilateral amputee who uses a wheelchair, line up on the third floor, next to the stairs. Ex. 34 at 25.

Despite the significant number of elderly patients and other patients with mobility disabilities at the Hospital, and the needs of some patients for regular physical therapy, Ex. 44 at 11; Ex. 4, Medical Care Chart at 92, Defendant admits that it does not employ a licensed physical therapist, Ex. 735 at 9; see also Ex. 551, 1/19/06 Letter to ULS.²²

2. Patients with Cognitive Disabilities

Patients with cognitive disabilities require individualized habilitative treatment for appropriate care and progress, but the Hospital fails at its job of identifying and assessing these patients, and reassessing when necessary, which are prerequisites to providing appropriate treatment. Ex. 9 at 10-11, 17; Ex. 25 at 204:8-205:1; 205:16-206:4; Ex. 47 at 4, 7-8, 41. “Given that many patients at St. Es have histories of head trauma, [intellectual disabilities], and present a confusing diagnostic picture, considerably more neuropsychological expertise is required to

²²Though not a mobility disability, during the last CMS survey, surveyors learned that the Hospital had not provided an amplification device for at least one patient with a hearing disability. Ex. 49 at 22. This too is a failure to accommodate a physical disability.

conduct evaluations and provide input on neurocognitive functioning for treatment planning.” Ex. 44 at 11; see also Ex. 32 at 161:22-162:18.

The treatment mall does not have programs that are suited to patients with cognitive disabilities. Ex. 32 at 272:6-273:5; Ex. 44 at 1, 3; Ex. 407, 8/2/06 E-mail Washington to Fain. Cognitive development groups that the Hospital had developed no longer exist. Ex. 32 at 121:16-21. Some patients with cognitive disabilities attend the Restorative Care program, which is designed for patients who are too medically compromised to leave the building; however, these programs are not modified for individuals with cognitive impairments. Ex. 42 at 62. The only assistive technology devices the Hospital has on the treatment mall are too antiquated to aid in treatment of individuals with cognitive disabilities. Ex. 10, Fain Depo. at 248:19-249:7; see also Id. at 247:21-248:11.

Defendant has failed to develop behavior plans for many patients with cognitive disabilities on the behavior management ward. Ex. 9 at 15; Ex. 25 at 200:14-201:10; 203:5-7; 205:16-206:4; Ex. 32 at 174:12-16, 175:20-176:1, 209:5-15; Ex. 729 at ¶¶ 26-27. Notably, many patients repeatedly involved in unusual incidents are individuals with cognitive disabilities. Ex. 2, Safety Chart at 18-21 (names noted in bold).

The Hospital does not have staff with the skills necessary to treat patients with cognitive disabilities, and the staffing levels are not adequate to provide needed individual supervision. Ex. 44 at 10; Ex. 10 at 245:21-246:12, 249:9-250:4; Ex. 729 at ¶ 27. Direct care staff has not received formal training on treating patients with cognitive disabilities. See, e.g., Ex. 23 at 221:12-223:1; Ex. 16 at 193:14-197:4; Ex. 10 at 250:6-10; Ex. 11 at 143:12-14, 144:3-5. When members of her staff expressed concerns about doing group psychotherapy with patients with limited cognitive functioning, the Director of Psychology recommended certain books to learn

some of the issues, and did some counseling with staff. Ex. 32 at 205:18-206:21. After the homicide in January 2007, staff acknowledged that all staff needs training on working with patients with intellectual disabilities. Ex. 738, Death Investigation at 11.

G. St. Elizabeths Fails to Respect Patients' Rights

Defendant's inability or unwillingness to address the serious problems facing the Hospital over the past two years demonstrates Defendant's lack of basic respect for the rights of the patients it is supposed to serve. Defendant's own expert concludes that "the extraordinary costs of maintaining archaic and often failing mechanical systems, and maintaining patient hygiene areas that are aesthetically decrepit, all amplify the perception of malaise, abandonment, and an inherent disrespect of the patient." Ex. 20 at 13.

Additional examples of dignitary harm to patients abound. The Hospital still does not have a Consumer Rights Policy. Ex. 34 at 23. It does, however, have a comprehensive Code of Conduct for patients, but not one for the staff. *Id.* at 26. Patients are not involved in their own treatment planning in a meaningful way. Ex. 47 at 37-39. Forty-one (41%) percent of patients surveyed report that they have not been treated with respect and dignity by hospital staff. Ex. 522, SEH Patient Satisfaction Survey Report FY 06.

A generally hostile atmosphere exists on many wards at the Hospital. Staff yells at patients, Ex. 514, 12/22/05 E-mails between Wade, Gore and Jibril at 4; Ex. 729 at ¶ 8, and speak to them disrespectfully, Ex. 730 at ¶ 13. Patients complain that staff is unnecessarily rough at times. Ex. 729 at ¶¶ 9-10. While many patients at the Hospital are incontinent of feces and urine, staff does not address the issue. Ex. 44 at 6. Forty-eight (48%) percent of patients report that they do not have enough privacy. Ex. 522 at 6. For example, patient bedrooms do not have privacy drapes, Ex. 42 at 4, and some of the bathroom stalls do not have doors, Ex. 729

at ¶ 15. Many patients do not feel that they have a voice at the Hospital, and some are fear retaliation if they voice their concerns. Ex. 9 at 8, 19; Ex. 25 at 211:18-212:7; Ex. 522 at 6. Such fear of retaliation “prohibits a consumer-driven treatment environment.” Ex. 38 at 34 (attachment 2).

Though the bruises may not be visible, this treatment significantly harms patients. The daily abuse results in a loss of dignity and self-respect such that patients cannot recover from their mental illness.

III. Argument

For more than two years, Defendant has continued to violate the constitutional and statutory rights of the patients at St. Elizabeths. For more than two years, Defendant has made empty promises of reform. Defendant has not demonstrated the ability or the commitment to remedy these violations in a sustainable way, and an injunction is necessary to secure patients’ safety and protect their rights.

A. The Court Should Issue A Permanent Injunction To Prevent Defendant’s Ongoing Constitutional and Statutory Violations

The basis for injunctive relief, as an equitable remedy, is irreparable injury and the absence of an adequate remedy at law. Weinberger v. Romero-Barcelo, 456 U.S. 305, 312 (1982); U.S. v. District of Columbia, 703 F. Supp. 982, 984 (D. D.C. 1988). The Court uses its discretion to balance the potential harm to the parties, along with consideration of the public interest. Universal Shipping Co. v. U.S., 652 F. Supp. 668, 676 (D. D.C. 1987). The factors for deciding whether to grant a permanent injunction are essentially the same as those for a preliminary injunction, except that instead of a likelihood of success, the plaintiff must show actual success on the merits. Amoco Prod. Co. v. Vill. of Gambell, 480 U.S. 531, 546 n.12 (1987); ACLU v. Mineta, 319 F. Supp. 2d 69, 87 (D. D.C. 2004); Iowa Prot. & Advocacy Servs.

v. Rasmussen, 206 F.R.D. 630, 634 (S.D. Ia. 2002). Thus, Plaintiffs must demonstrate: (1) success on the merits; (2) that irreparable injury will occur if the relief is not granted; (3) that an injunction would not substantially injure other interested parties; and (4) that the public interest would be furthered by the injunction. ACLU, 319 F. Supp. 2d at 87.

Plaintiffs easily satisfy all of the requirements for issuance of an injunction. Defendant has long known of the myriad problems facing the Hospital, and the attendant danger to patients and staff. Despite countless reports of the Hospital's inadequacies, Defendant still has not created a safe treatment environment for patients. In the absence of a permanent injunction, Plaintiffs will continue to suffer irreparable harm to their mental and physical health and safety. The aggregate benefits to the patients at St. Elizabeths, and to the community at large, outweigh any inconvenience to Defendant, which legally must provide adequate care and protection from harm to patients. Moreover, an injunction serves the public interest by preventing Defendant from continuing to subject patients to unsafe and unsanitary conditions, discriminatory conduct and dignitary harm.

1. Success on the Merits

a. Defendant Fails to Provide Patients Safe Care in Violation of Their Substantive Due Process Rights

Patients committed at St. Elizabeths have a constitutional interest in adequate treatment and safe conditions protected by the Due Process Clause of the Fifth Amendment to the United States Constitution. See Youngberg v. Romeo, 457 U.S. 307, 324 (1982); see also Oregon Advocacy Ctr., Inc. v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003). These fundamental liberty interests include the right to protection from harm, the right to be free from unnecessary confinement and restraint and the right to receive adequate treatment to secure these rights. See Youngberg, 457 U.S. at 319, 324; United States v. Jackson, 553 F.2d 109 (1977); Thomas S. v.

Flaherty, 902 F.2d 250 (4th Cir.), cert denied, 498 U.S. 951, 111 S. Ct. 373 (1990) (“Thomas S. IV”).

Plaintiffs are likely to succeed on the merits of their claim that Defendant is depriving patients of their constitutional rights to personal safety and security. The right to personal security constitutes “an historic liberty interest” protected substantively by the Due Process Clause. Ingraham v. Wright, 430 U.S. 651, 673 (1977). In Youngberg, the Supreme Court found that individuals committed to a state institution have a Fourteenth Amendment liberty interest in personal safety and security. See id.; Estate of Connors by Meredith v. O’Connor, 846 F.2d 1205 (9th Cir. 1988), cert denied, 489 U.S. 1065, 109 S. Ct. 1338 (1989).

Defendant assumes the constitutional duty to provide for the basic human needs of those whom it institutionalizes. Fialkowski v. Greenwich Home for Children, 683 F. Supp. 103, 105 (E.D. Pa. 1987); Sabo v. O’Bannon, 586 F. Supp. 1132, 1138-41 (E.D. Pa. 1984). When the District of Columbia takes individuals into its custody and holds them there against their will, the Constitution imposes a corresponding duty to assume some responsibility for their safety and general well-being. See DeShaney v. Winnebago County Dep’t. of Social Servs., 489 U.S. 189, 199-200 (1989), citing Youngberg, 457 U.S. at 314-325.

The numerous exhibits attached hereto demonstrate that the conditions at St. Elizabeths are unsafe and unsanitary, and constitute an unconstitutional violation of the rights of the patients who are housed there. Absent injunctive relief, this irreparable harm will continue and the patients will be at risk of further irreparable harm. Specifically, Defendant: (1) fails to ensure that there are adequate numbers of qualified staff on each ward to supervise and care for the patients so as to protect the patients from hurting themselves or others; (2) inappropriately uses seclusion and physical and chemical restraints in an effort to manage patients’ behavior; and (3)

fails to address the numerous unsanitary conditions and deteriorated physical environment in which patients must live.

St. Elizabeths lacks sufficient numbers of staff across all disciplines. See supra at II.C.1. Inadequate staffing seriously impacts the competency of the direct care staff. See supra at II.C.2. Patient-on-patient assaults and injuries occur almost daily, and Defendant does not develop timely interventions to address patient aggression before it leads to injuries. See supra at II.A. Defendant does not conduct appropriate follow-up or investigate serious incidents. See supra at id.

Defendant continues to use seclusion and restraint at unacceptable levels, and its usage is increasing again. See supra at II.D. Because staff are not trained in appropriate de-escalation techniques and Defendant does not develop behavior intervention plans for patients who need them, seclusion and restraint is used more frequently than it should be. See supra at id. Additionally, the Hospital relies heavily on chemical restraint to control patients' behavior. See supra at id.

The unsafe and unsanitary physical conditions are overwhelming. Patients must live on dilapidated wards that are not conducive to recovery and have a direct impact on patient care. See supra at II.E. Inadequate infection control, fires, pests, excessive temperatures, broken elevators and insufficient supplies all remain serious problems. See supra at id.

b. Defendant Violates Plaintiffs' Constitutional Rights to Adequate Care and Treatment

Patients who are confined to a public psychiatric hospital, such as St. Elizabeths, also have a Fifth Amendment right to adequate care and treatment. Youngberg, 457 U.S. at 319-320. Such care and treatment must provide the patient with a "realistic opportunity to be cured or to improve the mental condition for which they were confined." Sharp v. Weston, 233 F.3d 1166,

1172 (9th Cir. 2000); Brooks v. Morrow, 781 F.2d 367, 369 (4th Cir. 1986) cert. denied, Kirk v. Thomas S. by Brooks, 474 U.S. 1124 (1986); Ohlinger v. Watson, 652 F.2d 775 (9th Cir. 1980); Or. Advocacy Ctr. v. Mink, 322 F.3d 1101 (9th Cir. 2003).

“An essential element of the constitutional right to minimally adequate treatment is a humane physical and psychological environment.” Flakes v. Percy, 511 F. Supp. 1325, 1339 (W.D. Wis. 1981); see generally Youngberg, 457 U.S. 307. “Plaintiffs have the constitutional right to minimally adequate habilitation . . . which will *tend* to render unnecessary the use of chemical restraint, shackles, solitary confinement, locked wards, or prolonged isolation from one’s normal community. . .” Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200-1201 (W.D.N.C. 1988), aff’d, 902 F.2d (4th Cir. 1990) (italics in original). “Physical and chemical restraints must not be used, inter alia, as punishment, for the convenience of the staff, or as a substitute for activities or treatment.” Lels v. Kavenaughz, 673 F. Supp. 828, 837 (N.D. Tex. 1987) (quoting 42 C.F.R. §§ 442.404, 442.438, 442.440) . “It is a substantial departure from professional standards to routinely rely on seclusion and restraint rather than systemic behavior techniques such as social reinforcement to control aggressive behavior.” Thomas S., 699 F. Supp. at 1189.²³

Defendant’s and Plaintiffs’ experts agree that the treatment that Defendant provides to patients at St. Elizabeths fails to meet professional and constitutional standards.²⁴ Defendant does not conduct appropriate or timely psychiatric and psychological assessments, develop individualized treatment plans or coordinate treatment plans in conjunction with the limited

²³ See also id. at 1188 (drugs given to control a patient’s behavior are a form of restraint).

²⁴ St. Elizabeths does not have accreditation from the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”). JCAHO is an independent organization that evaluates the quality and safety of care for more than 15,000 health care organizations, including psychiatric hospitals. It is “the nationally acknowledged accrediting institution.” See Ex. 719, 12/17/04 DMH Press Release at 2. As the Second Circuit has held, “where a facility lacks accreditation by [JCAHO], not even a prima facie showing of adequacy exists.” Woe v. Cuomo, 729 F.2d 96, 107 (2nd Cir. 1984).

therapeutic activities offered. See supra at II.B. Defendant's own expert concluded that the Hospital does not provide active psychiatric treatment to most patients. Ex. 22 at 4. The Hospital does not have enough direct care staff, including psychiatrists, registered nurses, psychologists and general medical officers to provide minimally adequate care. See supra at II.C. Without the means to provide active psychiatric treatment, Defendant relies excessively on medications. See supra at II.B. Defendant also provides substandard medical care, and patients have suffered significant injuries as a result. See supra at II.C.2.a. Furthermore, the unsanitary and unsafe conditions of the physical plant compromise patients' safety and their treatment. See supra at II.E.

c. Defendant Violates the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973

Defendant has deprived and continues to deprive patients at St. Elizabeths of their rights under Title II of the Americans with Disabilities Act, and the regulations promulgated thereunder. 42 U.S.C. § 12132; 28 C.F.R. Part 35. See District of Columbia v. Ramirez, 377 F. Supp. 2d 63 (D.D.C. 2005); Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460 (E.D. Pa. 1998); see also Townsend v. Quasim, 328 F.3d 511, 517-518 (9th Cir. 2003); Williams v. Wasserman, 937 F. Supp. 524 (D. Md. 1996); Messier v. Southbury Training Sch., 916 F. Supp. 133 (D. Conn. 1996). An individual with a disability may not be denied "participation in or be denied the benefits of the services, programs, or activity" of a public entity "or be subjected to discrimination" by a state or local government because of their disability. 42 U.S.C. § 12132. The District of Columbia is a public entity within the meaning of the ADA, Galloway v. Superior Court of D.C., 816 F. Supp. 12 (D.D.C. 1993); see also 42 U.S.C. § 12131(1)(B). Yet Defendant has violated and continues to violate Title II of the ADA by excluding or denying benefits, or otherwise discriminating against individuals with disabilities at St. Elizabeths who are otherwise

qualified to participate in the Hospital's services, programs or activities. McGary v. City of Portland, 386 F.3d 1259, 1265 (9th Cir. 2004); Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998); Yeskey v. Pa. Dep't of Corr., 118 F.3d 168 (3d Cir. 1997). Defendant has failed and continues to fail to furnish appropriate auxiliary aids and services to provide patients with mobility and cognitive disabilities an equal opportunity to participate in the activities of the Hospital. Ramirez v. D.C., 2000 WL 51778, 2000 U.S. Dist. LEXIS 4161 (D.D.C. 2000).

As a public entity, St. Elizabeths is required to "make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(a), (b)(1)(i), (b)(1)(ii), (b)(1)(iii). Defendant, however, has failed and continues to fail to make reasonable accommodations in its policies, practices, and procedures to enable patients at St. Elizabeths who are also qualified individuals with a disability, to participate fully and equally in and enjoy public services, programs, and activities provided by Defendant to other patients at St. Elizabeths, in violation of the ADA.

Patients who have mobility disabilities often do not receive appropriate treatment because Defendant does not accommodate their physical needs and does not offer alternative treatment when patients cannot attend the treatment mall. See supra at II.F.1. Patients with cognitive disabilities are also not provided appropriate, individualized habilitation at the Hospital. See supra at II.F.2. Staff lack the skills to treat patients with cognitive disabilities, including traumatic brain injury, and the Hospital offers no specialized training in these areas. See supra at II.F.2. Defendant does not create behavior intervention plans or utilize assistive technology devices to accommodate patients' cognitive functioning. See supra at II.F.2.

Also, Defendant has deprived and continues to deprive patients who also have mobility disabilities or cognitive disabilities of their rights as secured by Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and the regulations promulgated thereunder, 28 C.F.R. Part 41 and 42 U.S.C. § 1983. Courts apply Title II of the ADA and Section 504 of Rehabilitation Act consistently. “In view of the similarities between the relevant provisions of the ADA and the Rehabilitation Act and their implementing regulations, courts construe and apply them in a consistent manner.” Radaszewski on behalf of Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004); Frederick L. v. Dep’t of Pub. Welfare, 364 F.3d 487, 491 (3d Cir. 2004); see also Ferrell v. Howard Univ., 1999 WL 1290834, 1999 U.S. Dist. LEXIS 20900 (D.D.C. 1999).

d. Defendant Violates Plaintiffs’ Statutory Rights Under the D.C. Mental Health Consumers’ Rights Protection Act

Defendant has violated and continues to violate Plaintiffs’ statutory rights under the District of Columbia Mental Health Consumers’ Rights Protection Act (“DCMHCRPA”), D.C. Code § 7-1231.01-1231.15. The DCMHCRPA requires that treatment be provided in a manner that demonstrates respect for the consumer’s dignity, autonomy, and privacy, and is free of physical, emotional or financial abuse, neglect, harassment, and coercion, id. at §7-1231.04(a) & (c). As a mental health provider, the Hospital is required to provide “individual mental health services and mental health supports in the least restrictive, most integrated setting appropriate to ... [patients’] individual needs,” D.C. Code at §7-1231.04(d). The DCMHCRPA also requires Defendant to provide treatment that is free from restraint and seclusion that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff. D.C. Code § 7-1231.09. Finally, the DCMHCRPA prohibits discrimination on the basis of physical or mental disability. D.C. Code § 7-1231.04(b). Defendant have failed to meet any of these basic requirements.

i. Physical abuse, emotional abuse, harassment, and neglect

In violation of DCMHCRPA § 7-1231.04(a) & (c), Defendant continues to fail to provide treatment that is free of physical and emotional abuse, neglect, and harassment. Patients at the Hospital regularly experience violence, with assaults occurring on an almost daily basis. Physical abuse by other patients is rampant, see supra at II.A., and due to staff shortages, see supra at II.C., inadequate behavior interventions, see supra at II.A., little is done to protect patients from this harm. Patients are subjected to emotional abuse and harassment as they are yelled at by staff, see supra at II.G. Neglect also abounds. Consumers do not even have their basic needs attended to: toilet paper is often unavailable, plumbing is constantly out of service, pests and rodents are commonplace, and the temperature is often uncomfortably hot or cold, see supra at II.E.

ii. Denial of individualized mental health treatment in the least restrictive, most integrated setting appropriate to consumers' needs.

Under the DCMHCRPA, mental health treatment must be both individualized and provided in the least restrictive and most integrated setting appropriate. D.C. Code §7-1231.01-1231.15. The treatment provided at the Hospital is not individualized, as evidenced by the lack of meaningful treatment goals and behavioral plans, see supra at II.B.1. The lack of active mental health treatment consigns consumers to unreasonably long stays at the Hospital, with little hope for release, denying their right to mental health treatment in the least restrictive setting.

iii. Use of restraint and seclusion that is not medically necessary or as a means of coercion, discipline, convenience, or retaliation by staff.

Consumers must be free from restraint and seclusion that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff. D.C. Code § 7-1231.09. However, psychiatrists do not always conduct the required face-to-face assessments, nonviolent crisis interventions are not attempted on a consistent basis, nor are all staff even

trained in such techniques, see supra at II.D. Chemical restraint is used in the absence of an emergency, to control unwanted but nonviolent behavior. See supra at II.D. Defendant underreports the extent that restraint and seclusion are utilized at the Hospital, and therefore misrepresents the magnitude of this problem. See supra at II.D.

iv. Discrimination on the basis of physical and cognitive disability.

Defendant has failed and continues to fail to provide access to mental health services and mental health supports free of discrimination on the basis of physical or mental disability. D.C. Code § 7-1231.04(b). Consumers with mobility impairments do not always have appropriate access to bathrooms and are often excluded from the treatment mall. When this happens, individuals are not afforded alternative therapies. See supra at II.F.1. Similarly, individuals with cognitive disabilities are denied assistive technology, behavior plans, and treatment programs that meet their needs. See supra at II.F.2.

e. Defendant Violates Plaintiffs' Statutory Rights Under the D.C. Human Rights Act

Defendant has engaged and continues to engage in unlawful discriminatory practices regarding patients with mobility disabilities and cognitive disabilities “which [have] the effect or consequence of violating” the D.C. Human Rights Act. D.C. Code § 2-1402.68. The Act prohibits discrimination in public accommodations and public services, D.C. Code § 2-1402.11, .21, .31, .41, and specifically applies to public services provided by Defendant District of Columbia. D.C. Code § 2-1402.73. The DCHRA is a broad remedial statute, and is to be construed liberally. George Washington Univ. v. D.C. Bd. of Zoning Adjustment, 831 A.2d 921 (D.C. 2003). Violations of the ADA establish a prima facie case of disability discrimination under the DCHRA: Plaintiffs must show that they have cognitive or physical disabilities, that Defendant was aware of these disabilities, and that Defendant failed to offer Plaintiffs reasonable

accommodations. Scott v. District of Columbia, 2006 WL 1409770 (D.D.C. 2006) (Roberts, J.). Defendant is and has been aware that some patients at the Hospital have either cognitive and mobility disabilities. Defendant's failure to provide these patients with reasonable accommodations, such as accessible treatment locations, accessible bathrooms, individualized rehabilitative treatment and behavior plans for those with cognitive disabilities and traumatic brain injuries, as well as training for staff who works with them, denies these individuals equal opportunities for treatment, in violation of the DCHRA. See supra at II.F.1 and II.F.2.

2. Plaintiffs will Suffer Irreparable Harm if the Relief is Not Granted

To prevail on a request for injunctive relief, Plaintiffs must demonstrate that they will suffer irreparable harm if an injunction is not granted. Katz, 246 F.3d at 687; Va. Petrol. Jobbers Ass'n v. FPC, 259 F.2d 921, 925 (D.C. Cir. 1958); McVeigh v. Cohen, 983 F. Supp. 215, 218 (D.D.C. 1998); Elzie v. Aspin, 841 F. Supp. 439, 442 (D.D.C. 1993). As the facts overwhelmingly illustrate, Plaintiffs are suffering in inadequate, unhealthy facilities where safety is a constant concern. Without adequate numbers of qualified, competent direct care staff, Plaintiffs receive inadequate mental health and medical treatment, which significantly limits their recovery. See supra at II.A – II.G. All of this constitutes irreparable harm.²⁵

²⁵ Additionally, when an alleged deprivation of a constitutional right is involved, courts hold that no further showing of an irreparable injury is necessary. See Elrod v. Burns, 427 U.S. 347, 373-74 (1976) (holding that irreparable injury was shown where First Amendment interests were clearly either threatened or in fact being impaired at the time a preliminary injunction was sought); see also Nat'l People's Action v. Vill. of Wilmette, 914 F.2d 1008, 1013 (7th Cir. 1990), cert. denied, 499 U.S. 921; Mitchell v. Cuomo, 748 F.2d 804, 806 (2d Cir. 1984); Planned Parenthood v. Citiz. for Cmty. Action, 558 F.2d 861, 867 (8th Cir. 1977); Henry v. Greenville Airport Comm'n, 284 F.2d 631, 633 (4th Cir. 1960); Quaker Action Group v. Hickel, 421 F.2d 1111, 1116 (D.C. Cir. 1969).

Irreparable harm may be presumed here because Plaintiffs have clearly established that their constitutional rights are being violated. Similar to the court's holding in Quaker Action Group, the constitutional rights in this case are so basic that their deprivation should be found to constitute irreparable injury.

Moreover, a showing of irreparable injury may be presumed in certain instances of civil rights violations. Therefore, "a traditional showing of irreparable harm is not required when a Plaintiff seeks equitable relief to prevent the violation of a federal statute . . ." McKinney v. Town Plan and Zoning Comm'n, 790 F. Supp. 1197 (D. Conn. 1992) (citing Baxter v. City of Belleville, Ill., 720 F. Supp. 720, 734 (S.D. Ill. 1989)). Plaintiffs seek injunctive relief to prevent further violations of Title II of the ADA, Section 504, and constitutional and statutory

3. Injunctive Relief Would Not Substantially Injure Other Interested Parties

In the absence of an injunction, Plaintiffs continue to be at risk of serious injury by Defendant's failure to provide safe, sanitary conditions, and adequate treatment and care. By contrast, Defendant will only be required to act in accordance with the law by remedying the dangerous and unacceptable conditions at the Hospital. The "lack of funds, staff or facilities, cannot justify the State's failure to provide [those confined] with treatment necessary for rehabilitation." Turay v. Seling, 108 F. Supp. 2d 1148, 1151, aff'd in relevant part, 2001 WL 725277 (9th Cir. June 27, 2001); Rouse v. Cameron, 373 F.2d 451, 457 (D.C. Cir. 1966). Here, any harm Defendant might incur – however remote – if subjected to an injunction is substantially less than the irreparable harm and risk of irreparable harm that Plaintiffs have and will to continue to suffer if an injunction does not issue. The balance of the hardships in this case strongly favors Plaintiffs.

4. The Public Interest is Served By Issuance of an Injunction

The final factor bearing on the Court's determination whether to issue an injunction is the public interest. Express One Int'l, Inc. v. United States Postal Servs., 814 F. Supp. 87, 92 (D.D.C. 1992). Enforcement of the Constitution and federal and D.C. law weighs heavily in favor of granting an injunction. The Fund for Animals v. Clark, 27 F. Supp. 2d 8, 14 (D.D.C. 1998). In Fund for Animals, the court concluded that the public has a general interest in "the meticulous compliance with the law by public officials." Id. at 14.

The public interest considerations in this case clearly weigh in favor of Plaintiffs. An injunction will protect the lives of especially vulnerable individuals whom the District is entrusted to protect. Should an injunction issue, patients will be protected from unsafe and

claims. Like the plaintiff in McKinney, Plaintiffs have demonstrated facts sufficient to establish that patients' rights under the ADA and Section 504 are being violated.

unsanitary conditions at the Hospital, and will receive the care and treatment to which they are entitled. An injunction will also further Congress' intent in passing Title II of the ADA and Section 504 of the Rehabilitation Act. Finally, it will effectuate the civil rights protections of District of Columbia law. This Court should enjoin Defendant's ongoing violations and order Defendant to act in accordance with the law and as required by the attached proposed order.

B. The Court Should Issue a Declaratory Judgment that Defendant Has and Continues to Violate Plaintiffs' Constitutional and Statutory Rights

Plaintiffs seek relief under the Declaratory Judgment Act ("DJA") for a declaration that Defendant has violated and continues to violate the rights of individuals with mental illness in St. Elizabeths' care. The DJA provides that "in a case of actual controversy within its jurisdiction ... any court of the United States ... may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). The "actual controversy" requirement under the DJA has been interpreted to be the same as the "case or controversy" prerequisite for any exercise of federal jurisdiction under Article III, § 2, of the U.S. Constitution. Public Service Com. v. Wycoff Co., 344 US 237 (1952). The question in each case is "whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." Maryland Casualty Co. v. Pacific Coal & Oil Co., 312 U.S. 270, 273 (1941); see also Fed. Express Corp. v. Airline Pilots Assoc., 67 F.3d 961 (D.C. Cir. 1995).

Furthermore, the Court has discretion whether to entertain an action under the DJA. Wilton v. Seven Falls Co., 515 U.S. 277, 287 (1995). According to the Supreme Court, this discretion is to be exercised in the public interest, while balancing the needs of the plaintiff and the consequences of granting the declaratory judgment. Eccles v. Peoples Bank, 333 U.S. 426,

431 (1948). In Eccles, the Court noted that “[t]he actuality of the plaintiff's need for a declaration of his rights is therefore of decisive importance.” Among the factors that courts have considered are:

whether it would finally settle the controversy between the parties; whether other remedies are available or other proceedings pending; the convenience of the parties; the equity of the conduct of the declaratory judgment plaintiff; prevention of “procedural fencing”; the state of the record; the degree of adverseness between the parties; and the public importance of the question to be decided.

10 C. Wright & A. Miller, Federal Practice, § 2759; Jackson v. Culinary School of Washington, Ltd., 27 F.3d 573 (D.C. Cir. 1994), vacated on other grounds, 515 U.S. 1139 (1995).

It is clear that Defendant's refusal to acknowledge its ongoing violations of Plaintiffs' constitutional and statutory rights presents an “actual controversy” that warrants a Declaratory Judgment. The rights violations of which Plaintiffs complain are direct, immediate, and continuing, not hypothetical or abstract, and have substantially impacted the patients who have resided at St. Elizabeths since the initiation of this litigation. Defendants have continuously placed the health and safety of the patients under their care in peril due to substandard psychiatric and medical care and a blatant disrespect for their rights. Defendant's repeated insistence over the last two years that it is addressing the problems at St. Elizabeths and has plans for bringing the Hospital into compliance has been insufficient at best. Moreover, such promises have no bearing on the fact that the Hospital has failed to protect patients from harm and failed to provide them adequate treatment.

In the situation before the Court now, the justiciable controversy is of great public importance because it involves both a serious and continuous violation of Plaintiffs' rights and a considerable public interest, in that the lives of some of the District's most vulnerable individuals are a stake. The grant of a Declaratory Judgment that Defendant has and continues to violate Plaintiffs' rights far outweighs any potential negative effects such a declaration would cause to

the Defendant. Patients who have been systematically neglected and treated with such indignity deserve nothing less.

IV. Conclusion

For the reasons set forth above, Plaintiffs respectfully request that the Court grant their Motion for Permanent Injunction and Declaratory Judgment, and enter an order accordingly.

Respectfully submitted,

/s/ Mary Nell Clark
Mary Nell Clark (DC 419732)
Robin Thorner (DC 485492)
Patrick Wojahn (DC 483705)

UNIVERSITY LEGAL SERVICES, INC.
220 I Street, NE, Suite 130
Washington, D.C. 20002
(202) 547-0198

/s/ Lauren Reeder
Richard A. Schneider (GA 629569)
Lauren Reeder (DC 494572)

KING & SPALDING LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006
(202) 737-0500

Attorneys for Plaintiffs

This 9th day of April, 2007.