IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

UNITED STATES OF AMERICA, *Plaintiff,* v. STATE OF MISSISSIPPI, *Defendant.*	CIVIL ACTION NO. 3:16-CV-00622-CWR-FKB

UNITED STATES' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Findings of Fact

I. Introduction 1

II. The State of Mississippi Administers a Public Mental Health System that Includes State Hospitals and Community-Based Services. 1

III. Mississippi Operates Segregated State Hospitals. 4

IV. Mississippi Has Identified, Developed, and Endorsed the Framework of Services That Prevent Hospitalization. 6

A. Community-Based Services that Prevent Hospitalization 6

1. Programs of Assertive Community Treatment (PACT) 7

2. Community Support Services 8

3. Permanent Supported Housing 10

4. Supported Employment 13

5. Peer Support 14

6. Mobile Crisis Services 16

7. Crisis Stabilization Units 17

B. Effective Discharge Planning Connects Individuals in State Hospitals to These Services and Prevents Unnecessary Hospitalization. 17

V. Individuals with Serious Mental Illness in Mississippi Are Unnecessarily Segregated in Mississippi's State Hospitals Because They Do Not Receive Appropriate Community-Based Mental Health Services. 20

A. The United States Conducted a Random, Generalizable Review of State Hospital Patients. 20

B. Individuals with Serious Mental Illness Experience Long Admissions to State Hospitals. 23

C. Individuals with Serious Mental Illness Experience Repeated Admissions to State Hospitals. 24

D. Individuals with Serious Mental Illness Are Appropriate for and Would Benefit from Community-Based Services But Experience Unnecessary Hospitalizations Because They Do Not Receive Them. 25

1. There Are Insufficient Community-Based Services in Mississippi. 26

i. PACT 27

ii. Permanent Supported Housing 30

iii. Community Support Services 31

iv. Supported Employment 32

v. Peer Support 33

vi. Mobile Crisis Services 35

vii. Crisis Stabilization Unit Services 37

2. Many People Are Committed to State Hospitals Because They Do Not Have Access to Appropriate Community-Based Services. 39

3. State Hospital Discharge Planning is Inadequate. 42

4. Many Hospitalizations Are Unnecessarily Long Due to the Unavailability of Community-Based Services and the Lack of Effective Discharge Planning. 48

5. People Remain at Serious Risk of Hospitalization After Discharge Because They Are Not Connected to Community-Based Services Known to Reduce Hospitalization. 49

E. The Opinions of the State's Experts Are Non-Responsive to the United States' Claim and Not Persuasive. 51

VI. Individuals with Serious Mental Illness in Mississippi Do Not Oppose Receiving Services in the Community. 53

VII. The State Can Make Reasonable Modifications to Its Service System to Avoid Unnecessary Institutionalization and Those Modifications Do Not Constitute a Fundamental Alteration. 55

A. It Is a Reasonable Modification and Not a Fundamental Alteration for the State to Expand Community-Based Services and Provide Them to People Who Are in the State Hospitals and at Serious Risk of State Hospital Admission. 55

1. It Is Reasonable to Require Statewide Availability of Services the State Agrees Are Effective at Reducing Hospitalizations. 55

2. It Is Reasonable to Require Statewide Availability of Services Where the State is Already Obligated To Do So Under Medicaid Rules. 57

3. It Is Reasonable to Expand Community-Based Services Because It Is Cost-Effective. 58

i. The State Can Maximize Federal Medicaid Dollars to Fund Community-Based Services that Prevent Hospitalizations. 58

ii. The State Could Fund More Community-Based Services by Efficiently Allocating Grant Money. 62

iii. The State Could Repurpose Funds from State Hospitals to Community-Based Services that Reduce the Need for State Hospitals. 63

iv. State Hospital Care is Generally More Expensive than the Community-Based Services that Reduce the Need for State Hospital Care. 66

4. There Is a Clear Process For Expanding Statewide Provision of Community-Based Services to Prevent Hospitalization. 69

B. It is a Reasonable Modification to Identify, Screen, and Assess Individuals to Determine Their Appropriateness for Community-Based Services and Connect Them to Those Services. 72

C. It Is a Reasonable Modification to Engage in Effective Discharge Planning. 74

D. The State's Arguments That These Modifications Are Not Reasonable Because of Federal Law and Policies Is Wrong. 75

VIII. The State Cannot Establish Its Fundamental Alteration Affirmative Defense. 76

A. The State Cannot Identify Its *Olmstead* Plan. 76

B. The Documents Purportedly Forming the State's *Olmstead* Plan Are Insufficient. 77

C. Minimal Changes the State Has Made Over the Last Decade Do Not Constitute A Comprehensive, Effectively Working Plan. 81

1. The State Has Long Been on Notice of Its Title II Violation. 81

2. Reforms Have Been Made in Response to Litigation. 84

3. Reforms Have Not Remedied the Violation of Law. 85

IX. Individuals Who Are Unnecessarily Institutionalized In State Hospitals Experience Irreparable Harm. 89

Conclusions of Law

I. Applicable Law 93

A. The Americans with Disabilities Act Prohibits Unnecessary Institutionalization of People with Disabilities.. 93

B. The ADA Applies to People at Serious Risk of Institutionalization. 95

C. Public Entities Must Make Reasonable Modifications to Avoid Discrimination. 96

D. Defendants Bear the Burden of Establishing the Fundamental Alteration Affirmative Defense. 97

II. Mississippi is Violating Title II of the ADA. 99

A. Many People with Serious Mental Illness Are Institutionalized in Mississippi State Hospitals or Are at Serious Risk of Such Institutionalization Because They Do Not Receive Appropriate Community-Based Treatment. 99

1. State Hospitals Are Institutions that Segregate People with Serious Mental Illness from the Community. 100

2. People with Serious Mental Illness in Mississippi Are Qualified Individuals with Disabilities and Are Appropriate to Receive Community-Based Services. 100

B. Adults with Serious Mental Illness in Mississippi Do Not Oppose Receiving Services in the Community. 102

C. The State Can Make Reasonable Modifications to Accommodate Community-Based Treatment and Prevent Unnecessary Hospitalizations. 103

D. Mississippi Has Not Demonstrated a Fundamental Alteration Defense. 107

III. Declaratory and Injunctive Relief is Warranted. 110

FINDINGS OF FACT

I. Introduction

The State of Mississippi ("State") fails to provide intensive community-based services to adults with serious mental illness, placing them at serious risk of unnecessary institutionalization in one of four state-run segregated psychiatric hospitals and, when that risk is realized, of unnecessarily long institutionalization. This system, in design and operation, violates the Americans with Disabilities Act, 42 U.S.C. § 12132 ("ADA").

The State can reasonably modify its existing mental health system to prevent unnecessary State Hospital admissions by increasing community-based services, by providing effective discharge planning, and by using data to identify individuals in need of services and connecting those individuals to services. The State has failed to show that doing so is prohibitively expensive, or that it has a comprehensive, effectively working plan to avoid unnecessary hospitalizations in State Hospitals. Accordingly, it has not carried its burden to prove that these modifications would fundamentally alter its service system.

II. The State of Mississippi Administers a Public Mental Health System that Includes State Hospitals and Community-Based Services.

1. The State is a public entity under the ADA. Amended Trial Stipulations ("Trial Stip.") ¶ 1, ECF No. 231-1.[1]

2. The State administers and controls the State's mental health system primarily through the Division of Medicaid ("DOM"), which pays for mental health services for Medicaid-enrolled adults with mental illness, and through the Department of Mental Health ("DMH"),

[1] The Parties have stipulated to a fact cut-off as of December 31, 2018, with some exceptions. Stip. Regarding Supplementation of Disc. Resps. & Pre-Trial Matters ¶ 3, ECF No. 170.

which is the state agency responsible for providing mental health services to the eligible citizens of Mississippi. Trial Stip. ¶ 2; Miss. Code Ann. § 41-4-7.

3. Together, those agencies plan, fund, regulate, and oversee the State's mental health system, which includes the four State Hospitals and 14 regional community mental health centers ("CMHCs") that offer community-based mental health services. Trial Stip. ¶¶ 5-9; State's Answer ¶¶ 25-26, 69, 72, ECF No. 3; JX 53 at 6-7[2] (DMH FY 2019-FY 2021 Strategic Plan).

4. The four State Hospitals are Mississippi State Hospital in Whitfield, MS ("MSH"), East Mississippi State Hospital in Meridian, MS ("EMSH"), North Mississippi State Hospital in Tupelo, MS ("NMSH"), and South Mississippi State Hospital in Purvis, MS ("SMSH"). Trial Stip. ¶ 9.

5. All patients at the State Hospitals are involuntarily committed there. Trial Stip. ¶ 12.

6. Individuals admitted to or at serious risk of entry into State Hospitals have mental illnesses, such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. They are therefore persons with disabilities for purposes of the ADA. Trial Stip. ¶ 13.

7. The State offers community-based mental health services primarily through fourteen regional CMHCs. DMH is responsible for certifying, monitoring, and assisting the CMHCs. Trial Stip. ¶ 5.

8. DMH certifies each CMHC, promulgates Operational Standards for the CMHCs, conducts reviews of CMHC operations, awards grant funds to support specific community

[2] Citations to pages in JX and PX documents are to the page numbers in the bottom right-hand corner of the page.

services, and requires financial and performance reporting by CMHCs. Trial Stip. ¶ 7. DMH can certify providers of mental health services in addition to CMHCs. JX 60 at 13-14 (DMH Operational Standards); *see also* JX 23 at 5 (DOM service requirements, 23 Miss. Admin. Code Pt. 206, R. 1.1(D)(2) ("DOM Administrative Code")).

9. Despite the State's assertion that it does not control the actions of the CMHCs, *see, e.g.*, Allen Dep. 14:9-15:15, 45:15-23, June 14, 2018 ("oversight is a strong word"), the State has the authority to impose and enforce regulations on the CMHCs and make grant funding contingent on compliance with certain conditions. *See, e.g.*, JX 60 at 24 (DMH Operational Standards) ("Certification for any established period, service or program is contingent upon the program's continual compliance with current Operational Standards[.]"); PX 199 (DMH Funding Continuation Application Request for Mobile Crisis Response Team, May 26, 2017) (including outcome measures and reporting requirements); *see also* Trial Stip. ¶ 7 (DMH imposes requirements on, and conducts reviews of CMHCs); Trial Tr. 1398:11-16, June 17, 2019 (Peet)[3] ("[O]versight is not at all too strong a word."); Trial Tr. 2335:1-2, June 27, 2019 (Mikula) (acknowledging DMH needs to take more creative approach to ensure CMHCs offer key service).

10. The State requires that CMHCs offer certain mental health services ("core services"), including psychiatric services, individual and group therapy, community support services, crisis services, and peer support services. Some CMHCs also offer supported housing, supported employment, and Program of Assertive Community Treatment (PACT). Trial Stip. ¶ 6.

[3] Ms. Melodie Peet is an expert in mental health administration. Trial Tr. 1319:25-1320:5, June 17, 2019 (Peet). She has more than forty years of experience as a mental health administrator, including as commissioner of a state mental health agency. Trial Tr. 1312:19-23, 1313:15-1319:24, June 17, 2019 (Peet); PX 407 at 4 (Peet Report).

11. DMH drafts and updates its Operational Standards, which set definitions for services, eligibility for those services, staff training and qualification requirements, and certification standards. Trial Stip. ¶ 8.

12. The Mississippi Division of Medicaid designs, administers, and oversees Mississippi's Medicaid Program, including drafting the State's Administrative Code for Medicaid, which sets criteria that providers and managed care organizations use to determine whether services are medically necessary and reimbursable through Medicaid. Trial Stip. ¶¶ 259-61.

III. Mississippi Operates Segregated State Hospitals.

13. Mississippi's public mental health system prioritizes institutional care. PX 407 at 28-30 (Peet Report); Trial Tr. 1336:14-15, June 17, 2019 (Peet) ("[T]he [S]tate still has a hospital-centric view of their system."); Reeves Dep. 219:3-18, May 18, 2018 (SMSH Clinical Director testifying that SMSH had a desired outcome to maintain a 90 percent occupancy percentage for inpatient beds because "if you have low occupancy rates, it could be argued you don't need as many beds as you have"); *see also* PX 981 at 11 (FY 2018-FY 2020 DMH Strategic Plan) (strategic plan includes an outcome to reduce the average length of stay for certain forensic commitments, but no such outcome related to average length of stay for civilly committed adults); *infra* ¶¶ 171-73, 215-16.

14. As of 2018, the State had 438 State Hospital civil beds. PX412A at 1 (State Hospital Beds and Admissions [corrected]). Mississippi has one of the highest rates of inpatient psychiatric beds per capita in the country. PX 393 at 41-42 (Trends in Psychiatric Inpatient Bed Capacity, United States & Each State, 1970-2014); PX 394 at 27 (Trends in Total Psychiatric Inpatient and Other 24-Hour Residential Treatment Capacity, 1970 to 2014); Trial Tr. 1358:1-6,

June 17, 2019 (Peet); *see also* PX 1116 at 44 (2015 Mississippi State Department of Health Hospitals Report) (875 licensed psychiatric beds, not including State Hospitals).

15. The State pays between $360 and $474 per person per day for the State Hospitals. PX 452 at 38 (FY 2019 EMSH Budget Request); PX 453 at 30 (FY 2019 MSH Budget Request); PX 454 at 20 (FY 2019 NMSH Budget Request); PX 455 at 20 (FY 2019 SMSH Budget Request).

16. Between October 15, 2015 and October 15, 2017, Mississippi admitted 3,951 adults to its State Hospitals (and many of them more than once). PX 405 at 28 (MacKenzie Report).

17. State Hospitals are institutional, segregated settings. Trial Stip. ¶ 11; Trial Tr. 469:7-17, June 6, 2019 (VanderZwaag) (testimony from Deputy Chief Medical Officer of a state hospital that, "when someone is admitted to the hospital, I don't consider it an integrated setting"); Trial Tr. 569:3-7, June 10, 2019 (Duren) (testifying about things he enjoys in the community that he could not do while he was being treated in the State Hospital); *see also* PX 403 at 31, 136 (Baldwin Report); Trial Tr. 966:3-24, June 12, 2019 (Baldwin) (people interviewed described State Hospitals as a prison); Trial Tr. 511:7-15, June 6, 2019 (VanderZwaag) (psychiatric hospitals are "institutions, and the routine is determined by other people, and the food is determined by other people, and your privacy level is determined by other people").

18. People in State Hospitals do not have the opportunity to interact with their non-disabled peers. PX 407 at 14-18 (Peet Report); Trial Tr. 861:23-862:7, June 11, 2019 (Bell-Shambley) ("I think of an integrated setting being a setting where an individual has the opportunity to live and interact with individuals who do not have a mental illness, and the only

persons that a consumer would interact with at [an Alabama State] Hospital would be staff persons, so I don't think of a hospital as being an integrated setting at all.").

IV. Mississippi Has Identified, Developed, and Endorsed the Framework of Services That Prevent Hospitalization.

A. Community-Based Services that Prevent Hospitalization

19. It is undisputed that PACT, permanent supported housing, community support services, supported employment, peer support services, mobile crisis services, and crisis stabilization units (CSUs) can prevent hospitalizations. PX 404 at 9-15 (Drake Report); PX 407 at 10-14 (Peet Report); Trial Tr. 1322:14-25, 1324:2-20 June 17, 2019 (Peet) (crisis services, intensive case management, PACT, supported housing, supported employment, and peer support are key services that prevent unnecessary hospitalizations); Trial Tr. 1616:3-15, June 19, 2019 (Hutchins); Trial Tr. 2054:19-2056:1, June 25, 2019 (Allen) (mobile crisis, peer support, crisis stabilization, CHOICE housing, and supported employment reduce both hospitalizations and the need for hospital beds).

20. PACT, permanent supported housing, community support services, supported employment, peer support, mobile crisis, and crisis stabilization units have been implemented successfully throughout the country, including in rural states. *See* PX 1078 at 63 (SAMHSA ACT Toolkit) ("ACT programs have been implemented throughout the United States as well as in Canada, England, Sweden, Australia, and the Netherlands, and they operate in both urban and rural settings."); Trial Tr. 236:14-18, 238:20-239:6, 258:1-259:8, June 5, 2019 (Drake) (PACT can be modified for rural areas and when Dr. Drake monitored a modified model "we had very good outcomes, often the best outcomes in rural areas"); Trial Tr. 2056:2-16, June 25, 2019 (Allen) (the evidence-based practices Mississippi has chosen can be modified to meet local needs, including in rural areas).

21. Mississippi established PACT, community support services, supported employment, peer support services, mobile crisis services, and crisis stabilization units and promulgated regulations for each service in its Operational Standards for community mental health services. *See generally* JX 60 (DMH Operational Standards). Similarly, Mississippi established permanent supported housing through the CHOICE program. *See generally* JX 51 (Mississippi Home Corporation, CHOICE FY 2018 Annual Report).

22. Community support services, PACT, mobile crisis, crisis stabilization, and peer support are included in the Mississippi Medicaid State Plan. Trial Stip. ¶ 266; JX 23 (DOM Administrative Code); PX 96 at 11-17 (Approved Medicaid State Plan Amendment 2012-003).

1. Programs of Assertive Community Treatment (PACT)

23. PACT is the most intensive community-based service available in Mississippi. It is for individuals who have "the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs." JX 60 at 215 (DMH Operational Standards); *see also* Trial Stip. ¶ 189-190; JX 23 at 30 (DOM Administrative Code); PX 23 at 2 (DMH Press Release, Mississippi Expands PACT Teams); PX 407 at 12-13 (Peet Report); PX 404 at 13 (Drake Report).

24. PACT prevents hospitalizations. PX 23 at 2 (DMH Press Release, Mississippi Expands PACT Teams) ("Evidence-based programs such as PACT Teams are essential to keep individuals in the community and help them continue on their road to recovery."); PX 404 at 13 (Drake Report); Trial Tr. 134:10-135:7, June 4, 2019 (Drake) (research shows that ACT reduces the risk of hospitalization for people with SMI by 41% within the first year of receiving PACT); Trial Tr. 544:24-545:1, June 10, 2019 (Sistrunk) (PACT is "absolutely" effective at "preventing hospitalizations."); Trial Tr. 1616:3-1617:4, June 19, 2019 (Hutchins); Mikula Dep. 96:20-24,

Mar. 28, 2019 (PACT is effective at reducing hospitalizations); *see also* PX 1078 at 59-60 (SAMHSA ACT toolkit) ("Reviews of ACT research consistently conclude that, compared with other treatments . . . , when faithfully implemented, ACT greatly reduces psychiatric hospitalization and leads to a higher level of housing stability."); Trial Tr. 570:12-24, June 10, 2019 (Duren) (has not returned to a State Hospital since fully connecting to a PACT team); Trial Tr. 600:12-603:1, June 10, 2019 (Byrne) (PACT kept Person 62[4] out of a State Hospital); PX 401 at 37-38 (Byrne Report); Trial Tr. 1076:12-1079:4, June 12, 2019 (Burson) (PACT reduced Person 142's state hospitalizations); PX 406 at 125-26 (Burson Report).

25. PACT teams provide support by building relationships and having frequent contact with the individuals they serve. *See* Trial Stip. ¶¶ 192-93; Trial Tr. 399:1-23, 405:17-406:20, 411:5-23, June 6, 2019 (VanderZwaag) (First work of a team would be "assertive engagement, which is trying to develop some kind of alliance with [a person] around the things that [the person] feels would be important. . . before you even start talking about medicine."); Trial Tr. 532:16-533:2, 534:13-17, 539:15-541:15, June 10, 2019 (Sistrunk) (the frequency of PACT services is individualized and varies from a minimum of three times per week to five or more, depending on the individual's needs).

26. PACT is delivered by a mobile interdisciplinary team of mental health professionals, including a psychiatrist or psychiatric nurse practitioner, registered nurses, a substance abuse specialist, an employment specialist, and a peer specialist. Trial Stip. ¶ 191; Trial Tr. 2194:6-2195:5, June 26, 2019 (Crockett) (PACT team is mobile and "take[s] those services directly to" clients).

2. *Community Support Services*

[4] PX 400, filed under seal, identifies the names of individuals referred to in this document as "Person __."

27. Community support services are mobile support services that help people avoid hospitalization and remain stable in the community. *See* JX 23 at 23 (DOM Administrative Code); JX 30 at 27 (DMH Community Mental Health Services FY16-FY17 State Plan) (intensive community support services "are a key part of the continuum of mental health services," and they "promote independence and quality of life through the coordination of appropriate services and the provision of constant and on-going support as needed"); JX 60 at 121 (DMH Operational Standards); PX 407 at 10, 12-13 (Peet Report); Trial Tr. 962:5-963:10, June 11, 2019 (Baldwin) (case management helps keep individuals in the community and can be provided as part of or separately from a PACT team); Trial Tr. 1326:15:24, 1342:24-1343:12, 1344:11-15, June 17, 2019 (Peet) (effective community support services prevent hospitalizations by intervening early in the trajectory of a crisis); Day[5] Dep. 224:24-225:2, Mar. 22, 2018 (community support services help adults with SMI stay out of the hospital).

28. Services encompassed in community support services include medication management, crisis intervention, assistance with accessing services and pursuing recovery goals, in-home supports, and family psychoeducation. JX 23 at 23-24 (DOM Administrative Code); JX 60 at 121 (DMH Operational Standards).

29. By design, the frequency and intensity[6] of those services should vary according to each individual's needs. JX 60 at 121-22 (DMH Operational Standards).

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[5] Andrew Day is a former director of DMH's Bureau of Community Services. Day Dep. 8:24-9:1 (Mar. 22, 2018). In May 2017 he became the director of certification at DMH. Day Dep. 72:7-8, 72:15-16 (Mar. 22, 2018).

[6] The State provides grant funding for community support services and for intensive community support services. PX 182 (Adult Community Services Grants FY17). Intensive community support services are provided by staff with smaller caseloads to individuals with high intensity needs. JX 30 at 28 (DMH Community Mental Health Services FY 2016- 2017 State Plan).

30. Community support services can prevent hospitalization for people who do not need PACT services, but do need regular, in-home contact and support. *See* Trial Tr. 1326:15:24, 1342:24-1344:15, June 17, 2019 (Peet).

3. Permanent Supported Housing

31. Permanent supported housing ("PSH") is a service that combines housing supports (such as assistance locating an affordable, safe apartment; help negotiating with landlords; apartment and utilities setup; and ongoing consultation) with access to integrated affordable housing.[7] Trial Stip. ¶ 235 ("Permanent Supported Housing is an evidence-based practice that provides an integrated, community-based alternative to hospitals, nursing facilities, and other segregated settings."); Trial Tr. 677:10-16, 680:19-24, 685:5-12, June 10, 2019 (Parker); *see also* PX 163 (A Statewide Approach for Integrated Supportive Housing in Mississippi).

32. Permanent supported housing is effective at reducing unnecessary hospitalizations.[8] PX 396 at 7 (The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity) (PSH is effective at decreasing admissions to emergency departments and inpatient care); PX 404 at 12-13 (Drake Report); Trial Tr. 140:24-141:2, June 4, 2019 (Drake) (research shows that permanent supported housing reduces the risk of

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[7] Permanent supported housing is appropriate for most individuals with serious mental illness who have been in State Hospitals and require housing supports. DX 328 (Clinical Review Housing Recommendation). A small portion of individuals with serious mental illness who have been in State Hospitals are appropriate for supervised living arrangements. DX 328; Trial Tr. 141:3-9, June 4, 2019 (Drake).

The State currently has group homes and need not expand the supply of group homes in order to avoid institutionalization for the bulk of individuals who are currently in State Hospitals or at risk of such institutionalization. *See, e.g.*, PX 46 at 21 (Draft TAC Report) (TAC recommendations regarding PSH and group homes).

[8] For this reason, permanent supported housing can result in cost savings to the State. Trial Tr. 680:25-681:14, June 10, 2019 (Parker).

hospitalization for people with SMI by 33%); Trial Tr. 2215:3-8, June 26, 2019 (Crockett) (CHOICE has been effective in providing stable housing environments); *see also* Trial Tr. 570:12-24, 579:13-580:7, June 10, 2019 (Duren) (recipient of PACT and CHOICE housing services who credits those services with keeping him out of the State Hospital); Trial Tr. 680:25-681:14, 682:5-12, June 10, 2019 (Parker) (supported housing is a particularly effective program for people with serious mental illness; it typically leads to a "tremendous drop" in the use of emergency and crisis services, including emergency room visits); Trial Tr. 1955:23-1956:4, June 24, 2019 (Reeves) (housing is important to success in the community because if individuals are discharged from a State Hospital to an unstable environment, they often do poorly).

33. The "Housing First" approach to supported housing, which is utilized by the Department of Housing and Urban Development ("HUD"), the Department of Veterans Affairs ("VA"), and in communities across the country, engages people with services after housing is provided, rather than requiring that they accomplish certain requirements in order to be deemed "housing ready." As a result, "clients are more likely to actually meaningfully participate in the services that are provided to them when they're in their housing." Trial Tr. 676:17-678:19, 681:15-682:4, 682:5-12, June 10, 2019 (Parker); *see also* PX 404 at 12-13 (Drake Report) ("Research shows that [when housing is not conditioned on treatment] the great majority of clients (typically more than 90%) are able to maintain apartments, and most gradually enter treatment.").

34. Permanent supported housing offers clients autonomy and responsibility. By contrast, in a group home,[9] "typically it's not considered their home." Trial Tr. 680:5-18, June

[9] Group homes for adults with SMI are funded and regulated in Mississippi as "community living," also referred to as supervised living. JX 60 at 175 (DMH Operational Standards); Holloway Dep. 35:6-15, May 23, 2018. Services provided in group homes include staffing to assist with grooming, eating, food preparation, and other activities and

10, 2019 (Parker). "Most adults with serious mental illness want to live independently rather than with parents or in a group home." PX 404 at 12 (Drake Report); *see also* Trial Tr. 140:7-13, June 4, 2019 (Drake).

35. Mississippi provides permanent supported housing through the CHOICE Program—Creative Housing Options in Communities for Everyone—which targets individuals transitioning from State Hospitals to the community and those who have a history of multiple hospital visits in the last year due to mental illness. Trial Stip. ¶ 236; JX 1 (CHOICE flyer) (identifying priority categories for CHOICE applicants).

36. CHOICE was developed in response to a 2014 recommendation from the Technical Assistance Collaborative. PX 163 at 19 (A Statewide Approach for Integrated Supportive Housing in Mississippi); Trial Tr. 682:13-684:20, June 10, 2019 (Parker).

37. CHOICE was established in order "to meet in part Mississippi's responsibilities under the Supreme Court's Olmstead decision." JX 51 at 1 (Mississippi Home Corporation, CHOICE FY 2018 Annual Report).

38. CHOICE permanent supported housing is scattered-site housing. Individuals participating in the program can live in any safe, affordable apartment and are not grouped together with other individuals with serious mental illness. Trial Tr. 139:7-140:1, June 4, 2019 (Drake) (contrasting congregate and scattered-site housing); Trial Tr. 679:1-7, June 10, 2019 (Parker).

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do not include medical or psychiatric services. JX 60 at 175. The services are time-limited as it is intended to be transitional housing for individuals discharged from State Hospitals. *Id.* Individuals living in group homes may not have friends or family members living with them who are not also receiving services from the group home. *Id.* at 176. Up to eight people may live in a single group home certified under the Operational Standards. *Id.* at 177.

39. Individuals enrolled in permanent supported housing through CHOICE receive help finding and remaining in housing through the program, in addition to getting temporary rental assistance. Trial Stip. ¶¶ 238, 241; Trial Tr. 687:13-23, 688:2-11, June 10, 2019 (Parker).

40. Participation in CHOICE is typically limited to 12 months. During this time, providers should work with the individual to identify a long-term housing plan. Trial Tr. 690:20-692:1, June 10, 2019 (Parker). One option for people to receive long-term housing after they exit the CHOICE program is through public housing and Section 8 rental vouchers. *See id.* (Section 8 vouchers are among the options for people to transition to after CHOICE); JX 03 at 27 (Assessment of MAC Housing Goals and Strategies, April 2014). Participation can be extended if a long-term housing plan has not been developed by the end of 12 months. Trial Tr. 691:14-692:1, June 10, 2019 (Parker).

41. The CHOICE program is administrated by the Mississippi Home Corporation, in collaboration with DMH and two non-profit agencies, Mississippi United to End Homelessness ("MUTEH") and Open Doors. Trial Stip. ¶¶ 236, 238; Trial Tr. 675:17-676:2, 684:2-7, 690:16-19, June 10, 2019 (Parker).

4. Supported Employment

42. Supported employment is an evidence-based method for assisting individuals in obtaining and maintaining competitive employment, which can increase stability in the community. Trial Stip. ¶¶ 227-228; JX 52 at 9 (DMH FY18 Annual Report); JX 60 at 141 (DMH Operational Standards); Trial Tr. 109:8-11, June 4, 2019 (Drake); Trial Tr. 1104:24-1105:23, 1147:19-1148:9, June 12, 2019 (Burson) (supported employment also includes counseling to assist individuals with retaining benefits while working).

43. Supported employment is important to recovery and prevents hospitalizations. Trial Stip.¶ 228; JX 52 at 9 (DMH FY18 Annual Report) (employment plays a "critical role" in a person's "recovery journey"); JX 60 at 141 (DMH Operational Standards) ("The activities of Supported Employment help individuals achieve and sustain recovery"); PX 404 at 9-10, 14 (Drake Report) (supported employment leads to reduced use of hospital services); PX 993 at 12 (Lutterman Report) (defense expert witness opining that "[t]he ability to secure and sustain employment is important to recovery"); Trial Tr. 149:22-150:1, June 4, 2019 (Drake) ("[T]he data generally show that those people who become employed [through supported employment] reduce their use of hospitals pretty rapidly."); Trial Tr. 2055:19-21 (Allen) (supported employment reduces reliance on state hospitals); *see also* Trial Tr. 340:18-23, June 5, 2019 (Worsham) (employment has had "an amazing impact" on Ms. Worsham's well-being); Maddux[10] Dep. 44:13-21, May 7, 2018 (per MSH clinical director, "work can also be a significant therapeutic activity for these individuals and help build their self-esteem and give them a sense of accomplishment," as well as an income).

5. Peer Support

44. Peer support services promote stability and recovery in the community and are effective in preventing unnecessary hospitalization. JX 23 at 25 (DOM Administrative Code); JX 60 at 249-50 (DMH Operational Standards); PX 404 at 14-15 (Drake Report) (peer support can reduce hospitalizations); Trial Tr. 138:4-14, June 4, 2019 (Drake) (peer support helps to address risk factors for re-hospitalization, including substance use and housing instability); Trial Tr. 325:22-327:7, June 5, 2019 (Worsham) ("Knowing that there is somebody who understands

[10] Dr. Robert Maddux is the MSH Clinical Director and the DMH Medical Director. Maddux Dep. 6:8-14, May 7, 2018.

because they have been through it themselves, it means a lot. And what they have to say about how they got themselves well is something to listen to because they have been through it. . . . I have seen amazing progress in people's recovery" through peer support, including a change from thinking "that I'm just going to never work, nobody wants me because I'm sick," to "having a desire to go back to school or own a home or get married, you know, real life things." Peer support enables people to recognize that "not everything needs hospitalization[.]"); Trial Tr. 1956:17-1957:13 (Reeves); Trial Tr. 2055:6-9 (Allen) (peer support reduces reliance on State Hospitals); Day Dep. 37:23-38:1, Mar. 22, 2018 (peer support services are "very effective").

45. Peer support is provided by trained and certified individuals or family members of individuals who have received mental health services. Trial Stip. ¶ 251; *see also* Trial Tr. 316:16-21, June 5, 2019 (Worsham).

46. Peer support services give recipients of mental health services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms and challenges associated with various disabilities while directing their own recovery. Trial Stip. ¶ 252; JX 23 at 25 (DOM Administrative Code); JX 60 at 249 (DMH Operational Standards). *See* Trial Tr. 330:2-18, June 5, 2019 (Worsham) (peer support specialists "tend to be able to recognize when a person might be approaching a crisis," which enables them to address it early with that person and "let them know what kind of resources are available to them. And I think it gives people hope.").

47. Peer support contributes to successful transition planning from a State Hospital to the community. Kelly[11] Dep. 110:12-22, May 11, 2018 (peer support helps people transition back to community life after discharge); *see also* Trial Tr. 332:20-333:3, June 5, 2019

[11] Dr. Kelly is the clinical director of EMSH. Kelly Dep. 5:21-24, May 11, 2018.

(Worsham) (given losses people can experience as a result of State Hospital commitment, "peer support being able to help that person to transition back into the community, get back into the swing of life would be an awesome thing").

6. Mobile Crisis Services

48. Mobile crisis response is an intensive, evidence-based service designed to provide support to individuals experiencing a mental health crisis at their homes and other community locations, connect them to needed services, and prevent hospitalization. Trial Stip. ¶ 207 ("Without Crisis Response intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility."); JX 23 at 21-22 (DOM Administrative Code); JX 60 at 105 (DMH Operational Standards); PX 403 at 3-4, 9 (Baldwin Report); Trial Tr. 962:5-18, 983:5-13, June 12, 2019 (Baldwin) (goals of crisis services include diverting from the hospital whenever possible, stabilizing the individual, and connecting them to needed services); Day Dep. 167:15-23, Mar. 22, 2018 (DMH official testifying that mobile crisis is effective at preventing hospitalization because they "hopefully get to the person who's in crisis before it gets to the level where they would need to go to an inpatient setting"); Hurley[12] Dep. 62:22-63:2, Apr. 26, 2018.

49. Mobile crisis teams play a critical role in connecting individuals to other community-based services that help them to achieve stability and avoid future crises. JX 60 at 105-107 (DMH Operational Standards); PX 404 at 11 (Drake report); PX 407 at 11 (Peet Report).

[12] At the time of his deposition, Brent Hurley worked in DMH's Bureau of Community Services managing grants for, among other things, CSUs and mobile crisis teams. Hurley Dep. 7:7-8:8, 41:6-15, Apr. 26, 2018.

50. Crisis services are "a hallmark" of a comprehensive community-based service system because people "get challenged by their symptoms periodically and they need help." Trial Tr. 985:15-21, June 12, 2019 (Baldwin) (describing why crisis services were developed in Massachusetts beginning in 1978).

7. Crisis Stabilization Units

51. In Mississippi, Crisis Stabilization Units, also referred to as Crisis Residential Services or Crisis Stabilization Services, are short-term residential services designed to prevent civil commitment and/or longer-term inpatient hospitalization by addressing acute symptoms, distress, and further decompensation. Trial Stip. ¶¶ 212-13; JX 23 at 22-23 (DOM Administrative Code); JX 52 at 22 (DMH FY18 Annual Report); JX 60 at 109-113 (DMH Operational Standards); PX 404 at 11-12 (Drake Report); Trial Tr. 146:14-147:8, June 4, 2019 (Drake) (studies show that crisis services return people to a stable condition just as quickly as if they had gone to a hospital and that crisis supports reduce the risk of hospitalization for people with SMI by approximately 50%).

B. Effective Discharge Planning Connects Individuals in State Hospitals to These Services and Prevents Unnecessary Hospitalization.

52. Effective discharge planning begins soon after an admission to a State Hospital. Trial Tr. 611:18-612:24, June 10, 2019 (Byrne); Trial Tr. 1002:2-4, 1005:11-20, June 12, 2019 (Baldwin) (discharge planning beginning at admission is standard practice); Trial Tr. 1150:14-1151:2, June 13, 2019 (Burson); Reeves Dep. 48:3-13, May 8, 2018 (discharge planning should be done "fairly soon" after the patient is admitted).

53. Effective discharge planning requires close coordination between the State Hospitals and community providers from the beginning of the hospital admission. PX 404 at 22; (Drake Report); PX 407 at 26 (Peet Report); Trial Tr. 187:13-22, June 5, 2019 (Drake) (the

inpatient team, the patient, the family and the outpatient team should be involved in planning the transition); Trial Tr. 1002:8-21, 1005:11-20, June 12, 2019 (Baldwin) (coordination between the CMHC and the hospital, including the CMHC coming to the hospital before discharge, is effective discharge planning); Trial Tr. 1327:8-1328:22, June 17, 2019 (Peet) (coordination between community providers and hospitals decreases hospitalizations and lengths of stay "dramatically"); Maddux Dep. 61:21-62:10, 101:1-18, May 7, 2018 ("I would think that anybody that gets admitted to the hospital, coordination with their outpatient provider should be established," which could include collecting information about previous outpatient treatment plans and past medication trials; however, per MSH Clinical Director, such coordination is not required at MSH.); Mikula Dep. 49:22-52:6, 59:14-60:24, Mar. 28, 2019 ("smooth transition" requires communication between State Hospital and CMHC).

54. When community providers who will be working with an individual are involved in the discharge planning, they can identify community services and resources that will work, anticipate potential challenges, and build a relationship with the individual they will be serving. Trial Tr. 1328:13-22, June 17, 2019 (Peet) (community providers' knowledge of community treatment and resources makes a "big difference" in discharge planning); PX 407 at 26-28 (Peet Report); Trial Tr. 611:7-17, 612:4-614:3, 625:2-13, June 10, 2019 (Byrne) (involving community providers and putting appropriate services in place prior to discharge ensures "more of a seamless transition"); PX 401 at 9 (Byrne Report).

55. Effective discharge planning includes assisting the individual with applying for or reactivating income and health insurance benefits, such as SSI and Medicaid. Holloway[13] Dep.

[13] Sherry Holloway is a project specialist at DMH, Holloway Dep. 8:22-9:14, May 23, 2018, responsible for, among other things, PACT, community support services, and supported employment. *Id.* at 30:1-19.

151:12-151:20, May 23, 2018 (assisting individuals with social security income helps avoid hospitalization because "[i]f the individual has income and has a place to live, has the services, then most likely they will stay out of the hospital"); *see also* Trial Tr. 997:14-998:25, June 12, 2019 (Baldwin) (benefits assistance should "[a]bsolutely" be provided to people with serious mental illness); PX 403 at 206-09 (Baldwin Report); Trial Tr. 613:10-614:3, June 10, 2019 (Byrne); Fleming[14] Dep. 147:3-17, Apr. 11, 2018 (acknowledging importance of income and insurance); Lewis Dep. 138:1-18, May 21, 2018 (avoiding a gap in benefits coverage after a State Hospital discharge is important "[s]o that they can more easily or more successfully receive services upon discharge"); Newbaker[15] Dep. 84:13-20, Apr. 12, 2018.

56. Effective discharge planning for someone who has previously been admitted to a State Hospital includes taking into account the causes of the readmission and addressing them in the new discharge plan. Trial Tr. 615:25-618:8, June 10, 2019 (Byrne); Trial Tr. 1075:8-17, June 12, 2019 (Burson).

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[14] Jackie Fleming is MSH's social services director. Fleming Dep. 7:25-8:8, Apr. 11, 2018.

[15] Sheila Newbaker is EMSH's social services executive. Newbaker Dep. 11:13-18, Apr. 12, 2018.

V. Individuals with Serious Mental Illness in Mississippi Are Unnecessarily Segregated in Mississippi's State Hospitals Because They Do Not Receive Appropriate Community-Based Mental Health Services.

A. The United States Conducted a Random, Generalizable Review of State Hospital Patients.

57. Through a group of six experts (the "Clinical Review Team"), Dr. Judith Baldwin,[16] Dr. Beverly Bell-Shambley,[17] Katherine Burson,[18] Daniel Byrne,[19] Dr. Robert Drake,[20] and Dr. Carol VanderZwaag),[21] the United States conducted a review of a sample of

[16] Dr. Baldwin is an expert in psychiatric nursing, serious mental illness, and assessments for community-based mental health services. Trial Tr. 949:2-9, June 12, 2019 (Baldwin). Dr. Baldwin is a registered nurse with a master's degree in nursing; a doctoral degree in law, policy, and society; a clinical nurse specialist board certification in psychiatric nursing; and 47 years of psychiatric nursing experience. Trial Tr. 942:2-943:14, June 12, 2019 (Baldwin); *see generally* PX 403 at 3-8, 237-50 (Baldwin Report).

[17] Dr. Bell-Shambley is an expert in psychology, serious mental illness, and community-based mental health assessments. Trial Tr. 809:1-8, June 11, 2019 (Bell-Shambley). Dr. Bell-Shambley has a Ph.D. in clinical psychology, worked for 22 years in Alabama state psychiatric facilities, and worked for nine years in the central office of Alabama's mental health agency where she oversaw a statewide initiative to downsize state hospital units and expand community-based services. *Id.* at 803:12-808:9; *see generally* PX 408 at 1-3, 115-19 (Bell-Shambley Report).

[18] Ms. Burson is an expert in psychiatric occupational therapy, serious mental illness, and community-based mental health assessments. Trial Tr. 1064:11-1065:3, June 12, 2019 (Burson). Ms. Burson's work, spanning more than 30 years, has focused largely on what people with serious mental illness need in order to live successfully in the community, including coordinating institutional and community-based care and implementing evidence-based practices in Illinois. *Id.* at 1059:5-1064:10; *see generally* PX 406 at 1-2, 162-66 (Burson Report).

[19] Mr. Byrne is an expert in clinical social work and assessments for community-based mental health services. Trial Tr. 588:8-10, June 10, 2019 (Byrne). Mr. Byrne is a licensed independent clinical social worker with about 37 years of experience overseeing and providing mental health services to individuals with serious mental illness directly in psychiatric hospitals and community-based settings, through the supervision of others providing the same, and in consultation with mental healthcare providers in various states, including with ACT teams. *Id.* at 583:22-588:7; *see generally* PX 401 at 1-4, 133-36 (Byrne Report).

[20] Dr. Drake oversaw the clinical review in this case. Trial Tr. 89:24-90:2, June 4, 2019 (Drake); PX 404 at 1 (Drake Report). Dr. Drake has worked as a medical researcher in the mental health field and a psychiatrist for 45 years. Trial Tr. 89:17-20, June 4, 2019 (Drake); PX 404 at 2 (Drake Report). He has served as medical director for the community mental health center affiliated with the Geisel School of Medicine at Dartmouth; was the director of mental health research and planning for the State of New Hampshire, which included the state hospital and the 10 community mental health centers; and has led large clinical research projects around the country. Trial Tr. 94:13-23, June 4, 2019 (Drake); PX 404 at 3-4 (Drake Report).

[21] Dr. VanderZwaag is an expert in psychiatry and community-based mental health assessments. Trial Tr. 373:4-16, June 6, 2019 (VanderZwaag). Dr. VanderZwaag has served eight years as a psychiatrist and medical director in a state hospital, eighteen years on a full-fidelity PACT team and training other PACT teams, and is currently the

individuals who were in a State Hospital between October 15, 2015 and October 15, 2017 (the "Sample Period"). PX 404 at 1-2 (Drake Report); Trial Tr. 156:10-13, June 4, 2019 (Drake); *see also* PX 418 (map of last known addresses of individuals in the clinical review sample).

58. The purpose of the clinical review[22] was to evaluate a representative sample of patients who were hospitalized in Mississippi's State Hospitals and determine: (1) Would these patients have avoided or spent less time in the hospital if they had been provided reasonable community-based services? (2) Are the patients at serious risk of further hospitalization in a State Hospital? (3) Are the patients opposed to receiving reasonable community-based services? and (4) If the patients are appropriate for and would benefit from community-based services, what service would they need? PX 404 at 1-2, 4 (Drake Report); *see also* Trial Tr. 105:25-106:11, 106:23-107:12, June 4, 2019 (Drake).

59. The United States retained a statistics expert, Dr. Todd MacKenzie,[23] who worked with Dr. Drake to construct a random, representative sample, which ensured that the findings of the clinical review are generalizable to the population of Mississippians with SMI who have entered State Hospitals. PX 405 at 6 (MacKenzie Report); Trial Tr. 291:6-23, 293:4-6, 293:16-296:4, 298:3-14, June 5, 2019 (MacKenzie).

60. The State provided information about the individuals who had been admitted to a State Hospital during the Sample Period, and based on that information Dr. MacKenzie drew a

deputy chief medical officer at another state hospital. *Id.* at 370:16-373:3; *see generally* PX 402 at 1-2, 96 (VanderZwaag Report).

[22] The terms "client review" and "clinical review" were used interchangeably at trial to refer to the review of State Hospital patients.

[23] Dr. Todd MacKenzie, an expert in statistics and biostatistics, has been a statistics professor since 1997. Dr. MacKenzie spends roughly 80 percent of his time on research and has published articles in peer-reviewed publications that involved pulling samples similar to the one in this case. Trial Tr. 275:13-276:4, 276:15-20, June 5, 2019 (MacKenzie); PX 405 at 1 (MacKenzie Report).

sample of 299 individuals for use by the Clinical Review Team. PX 405 at 2-4, 28 (MacKenzie Report); Trial Tr. 276:24-277:5, 16-20, 278:20-23, 287:7-288:4, June 5, 2019 (MacKenzie).

61. Dr. Drake created an interview tool, incorporating input from the Clinical Review Team. PX 404 at 5-6 (Drake Report); Trial Tr. 166:9-168:9, June 4, 2019 (Drake). Using that tool, the Clinical Review Team interviewed 154 of the 299 individuals in the sample, in addition to reviewing their hospital and outpatient records and, where possible, interviewing family members and community service providers. PX 404 at 5-6 (Drake Report); Trial Tr. 164:20-165:11, 168:10-169:20 June 4, 2019 (Drake). Some were still in State Hospitals when the Clinical Review Team interviewed them in 2018. The interviewers wrote summaries answering the four questions posed above. PX 404 at 1-2 (Drake Report).

62. Dr. Drake also conducted a literature review, which entailed collecting and analyzing the most recent research on community-based services for adults with SMI. PX 404 at 5 (Drake Report); Trial Tr. 106:12-22. The purpose of the literature review was to ensure that the Clinical Review Team had consensus on "what these core services were and what they would look like and approximately how effective they might be in reducing hospitalization." Trial Tr. 106:12-22, June 4, 2019 (Drake).

63. Based on his review of all 154 reports, Dr. Drake identified themes and drew conclusions generalizable to the full population of adults with SMI committed to a State Hospital. PX 404 at 1-2, 6-7 (Drake Report); Trial Tr. 98:14-24, 105:25-106:11, 173:9-174:5, June 4, 2019 (Drake). The Clinical Review Team concluded that all of the 154 patients would have avoided or spent less time in a State Hospital if they had been provided reasonable community-based services, corresponding to 100% of all individuals admitted to a State

Hospital. PX 404 at 2 (Drake Report); Trial Tr. 107:13-18, June 4, 2019 (Drake); Trial Tr. 279:22-25, June 5, 2019 (MacKenzie).

64. 103 out of the 122 people who were in the community at the time of their interview were at serious risk for re-hospitalization, corresponding to 85.1% of all individuals admitted to a State Hospital. Trial Tr. 280:22-25, June 5, 2019 (MacKenzie); PX 404 at 2 (Drake Report); Trial Tr. 109:22-25, June 4, 2019 (Drake).

65. Only one of the 150 living sample members was opposed to receiving community-based services, meaning that 99.4% of all individuals admitted to a State Hospital were *not* opposed to receiving community-based services. Trial Tr. 110:15-25, June 4, 2019 (Drake); PX 404 at 2 (Drake Report); Trial Tr. 279:17-21, June 5, 2019 (MacKenzie).

66. The clinical review demonstrates that unnecessary and unnecessarily long hospitalizations occur across the state. PX 404 at 20-22 (Drake Report); Trial Tr. 312:14-19, June 5, 2019 (MacKenzie); PX 418; PX 417 (client review participants recommended for PACT are spread across the state, including many in counties where PACT is not available); *see also* PX 419 (high users of State Hospital resources come from 81 out of 82 counties); Trial Tr. 1338:8-20, June 17, 2019 (Peet) (people who use the State Hospitals most heavily are "distributed pretty uniformly across the state of Mississippi").

B. Individuals with Serious Mental Illness Experience Long Admissions to State Hospitals.

67. Many admissions to the State Hospitals last for months or years. PX 405 at 29 (MacKenzie Report, Exhibit C); *see e.g.*, Trial Tr. 729:14-19, 741:23-742:10, June 11, 2019 (H.B.) (testifying that his daughter S.B.'s[24] most recent admission to MSH was approximately

[24] S.B. and Person 25 are the same person. Trial Tr. 847:3-850:10, June 11, 2019 (Bell-Shambley).

four years and eight months, and that she has spent about 12 of the last 24 years in a State Hospital); PX 403 at 75, 182 (Baldwin Report); PX 408 at 41, 85, 92, 108 (Bell-Shambley Report).

68. More than 350 admissions lasted longer than six months. PX 405 at 29 (MacKenzie Report). Almost 850 additional admissions lasted between two and six months. *Id.*

69. As of FY 2018, Mississippi State Hospital had 92 beds in its continuing care unit, which is used specifically for long stays. Trial Stip. ¶ 69; *see also* PX 412A at 1 (Average Staffed Bed Capacity in State Hospitals [corrected]). The average stay in the continuing care unit is at least 4.5 years. PX 354 at 4 (DMH Fact Facts FY 2018) (1,656 days); Trial Tr. 2255:12-20, June 26, 2019 (Chastain) (2,500 days, or nearly seven years).

70. Although East Mississippi State Hospital does not have a dedicated long-term unit, some of the patients recently discharged from that institution were there for more than a decade. Carlisle[25] Dep. 73:8-17, June 15, 2018.

C. Individuals with Serious Mental Illness Experience Repeated Admissions to State Hospitals.

71. Dr. Drake, the lead clinical reviewer, called cycling admissions "the hallmark of a failed system." PX 404 at 15 (Drake Report); Trial Tr. 119:13-120:10, June 4, 2019 (Drake).

72. In total, 743 of 3,951 adults who were in State Hospitals during the Sample Period (October 15, 2015 to October 15, 2017) had more than one State Hospital admission *during that period*. PX 405 at 28 (MacKenzie Report, Exhibit C); *see also* PX 64 at 8 (MSH Utilization Review Committee Minutes, Aug. 17, 2017) (showing the male receiving unit recidivism rate, for the period 4/1/17-6/30/17, was 4% for 30 days, 8% for 60 days, 11% for 90

[25] Dr. Charles Carlisle is director of East Mississippi State Hospital. Carlisle Dep. 6:9-12, June 15, 2018.

days, and 28% for 365 days; for the female receiving unit, the recidivism rate for the same period was 5% for 30 days, 6% for 60 days, 10% for 90 days, and 24% for 365 days).

73. Just under half of those 3,951 adults had been admitted to a State Hospital at least once *before* the Sample Period began. PX 405 at 30 (MacKenzie Report, Exhibit C); *see, e.g.*, PX 401 at 33 (Byrne Report) (Person 61 has been in a State Hospital at least 19 times in as many years.); PX 406 at 137 (Burson Report) (Person 144 was admitted to a State Hospital three times between October 2016 and March 2018.); PX 402 at 69 (VanderZwaag Report) (At the age of 68, Person 46 had been admitted to a State Hospital 46 times. At the time of the review, 18 of his 46 admissions had occurred in the last seven years.).

D. Individuals with Serious Mental Illness Are Appropriate for and Would Benefit from Community-Based Services But Experience Unnecessary Hospitalizations Because They Do Not Receive Them.

74. The adults with mental illness who are committed to Mississippi's State Hospitals are appropriate for and would benefit from community-based mental health services.[26] Trial Tr. 961:4-962:4, June 12, 2019 (Baldwin) (It was not surprising that all individuals reviewed were appropriate for community-based services "[b]ecause I have seen it throughout my career that people can live successfully in the community at a very high level of independence who are also

[26] Testimony by witnesses for the State suggesting the opposite is outweighed by this evidence. Moreover, that testimony rested on "unwarranted assumptions" that persons isolated in State Hospitals are "incapable or unworthy of participating in community life." *Olmstead v. L.C.*, 527 U.S. 581, 600 (1999); *see* Trial Tr. 1691:10-17, June 20, 2019 (Lewis) (giving example of "someone who we don't want served in the community. . . . He needs to be inpatient. He doesn't need to be served on a PACT team or served in the community," without discussion of options for diversion or increased community support prior to crisis point); Trial Tr. 1817:22-1818:10, June 24, 2019 (Webb) (testifying regarding people with serious mental illness that "[p]eople like that can't work in the community when it's in a moderate to severe form . . . because they're not consistent with their thinking, they misperceive things, so they cannot work."); Trial Tr. 1864:24-1865:9, 1866:1-22, June 24, 2019 (Root) (describing persons with schizophrenia and schizoaffective disorder as finding "ways to be dysfunctional," contrasting them to "regular folks"). One of those assumptions is flatly contradicted by the record. *Compare* Trial Tr. 2040:8-25, June 25, 2019 (Allen) (people on the MSH continued treatment unit have "burnt every bridge"), *with* Trial Tr. 737:11-12, June 11, 2019 (H.B.) *and* Trial Tr. 2265:10-19, June 26, 2019 (Chastain) (H.B.'s daughter, who maintains a relationship with her father, was in the continued treatment unit).

living with serious mental illness. The community-based services are evidence-based. I have seen them work time and time again.").

75. Individuals with a history of aggressive behavior can be safely served in the community. Trial Tr. 981:3-8, June 12, 2019 (Baldwin) (individuals with a history of aggressive behavior can "absolutely" be safely served in the community; with services, "they can live at a very high level of independence"); *see* PX 404 at 11 (Drake report) ("Clinical standards require avoidance of inpatient care except in cases of acute and imminent dangerousness (rather than increased symptoms or non-adherence), and even then, community-based services successfully divert many admissions.").

76. State Hospitals should be a treatment option of last resort. Allen Dep. 25:21-26:4, 141:12-19, June 14, 2018 ("The goal would be to exhaust all available community resources prior to somebody having to come to a State hospital."); Maddux Dep. 78:7-12, May 7, 2018; Mikula Dep.106:15-107:4, Mar. 28, 2019 (Community-based services are intended to keep individuals with mental illness "away from an inpatient setting – or actually keep them out of crisis as well.").

77. When all other options have been exhausted, State Hospitalization should be as brief as possible. Trial Tr. 375:2-13, June 6, 2019 (VanderZwaag) (short length of stay is preferable because it enables person to recover and "mov[e] forward in their lives").

1. There Are Insufficient Community-Based Services in Mississippi.

78. There is a need for comprehensive community-based services all across the State. PX 211 at 2 (Email from Andrew Day, Sept. 30, 2016) (Community mental health services "need[] to permeate the whole state, not just pockets of the state."); Trial Tr. 1338:12-20, June 17, 2019 (Peet) (Heavy utilizers of State Hospital services are spread "all across the state of

Mississippi."); PX 419 (Home Addresses of the 30% of Patients who Account for 73% of Total State Hospital Bed Days October 2015 to October 2017); Trial Tr. 1616:16-1617:4, June 19, 2019 (Hutchins) (recognizing the need to expand community-based services like PACT across the State since 2011).

79. There is no dispute that there are areas of the State where some key community-based services are unavailable or insufficiently available. PX 407 at 19-24 (Peet Report); Trial Tr. 527:3-528:4, 528:13-17, June 10, 2019 (Sistrunk) (describing ongoing requests for PACT services from residents of counties that do not offer the service); Trial Tr. 1337:2-9, June 17, 2019 (Peet) (Key services "are not available across the state and equally accessible to people in different parts of the state."); Day Dep. 88:17-23, 279:13-280:2, Mar. 22, 2018 (stating that there are "areas of the state that for a variety of reasons may not have a particular service" and agreeing that not all CMHC regions have all recommended adult services); Hurley Dep. 121:20-122:5, Apr. 26, 2018 (Individuals in some areas of the State do not have access to a CSU in their catchment area, while CSUs that do exist have vacancies.); Hutchins Dep. 82:14-83:6, June 11, 2018 (acknowledging the need for CSU beds, PACT teams, intensive community support teams, and additional supportive employment sites).

i. PACT

80. The demand for PACT is high across the state. PX 281 (PACT referral tracking form); PX 417 (map of home addresses of client review members recommended for PACT services and locations of PACT teams); PX 419 (map showing Home Addresses of the 30% of Patients who Account for 73% of Total State Hospital Bed Days October 2015 to October 2017); Trial Tr. 1339:11-19, June 17, 2019 (Peet) (Comparison of maps shows that there is, "enormous unmet need," for [P]ACT services around the state.); Trial Tr. 2218:9-22, June 26, 2019

(Crockett) (noting recent expansion of PACT capacity because of additional need and confirming unmet need for PACT in Region 9).

81. However, as of June 2018, the service was not available in 68 of 82 counties, representing approximately 58% of Mississippi's population. PX 413 (map showing counties with PACT teams as of 6/30/2018); PX 920 (population by CMHC region and adult psychiatric admissions per region).

82. The teams that operate in the 14 counties with PACT are not operating at full capacity. Trial Stip. ¶¶ 195-201; JX 66 at 11 (FY 2014-2016 DMH Strategic Plan) (goal to fully operationalize PACT teams by FY 2016); PX 422 at 2 (graph showing actual PACT enrollment is consistently lower than system-wide capacity July 2014 to June 2018); Trial Tr. 1626:24-1628:8, 1629:2-16, June 19, 2019 (Hutchins) (PACT teams are not at full capacity and increasing PACT enrollment is a goal included in the DMH strategic plan.).

a. The full capacity of each PACT team is at least 80 people served at a given time. Trial Tr. 1609:23-34, June 19, 2019 (Hutchins) (PACT teams have a "capacity of 80 per team").

83. After June 2018, the State awarded grant funding to Regions 4 and 8 to start one PACT team in each region, for a total of 10 teams across the state. DX 12 at 2 (Updates to Community-Based Services). As of December 2018, the team in Region 8 was still not operational. Trial Tr. 1587:1-14, June 19, 2019 (Hutchins).

84. Even with these two additional teams, in four of the CMHC regions, PACT is not available anywhere. *See* PX 413 (Mississippi Counties with Program of Assertive Community Treatment Teams as of 6-30-2018).

85. DMH has not made PACT a core service, despite receiving recommendations that it do so since at least 2010. *See supra* ¶ 10; *compare* Trial Tr. 1185:2-4, 21-24, June 13, 2019

(Ladner) (MPA recommended in 2010 that ACT be made available throughout 82 counties) *and* PX 861 at 22 (Strategic Planning and Best Practices Committee Report to the Legislature, June 30, 2013) (recommending additional core services for adults with serious mental illness, including increased PACT teams) *with* Trial Tr. 1187:18-20, June 13, 2019 (Ladner) (as of the end of 2018, ACT was not a core service) *and* Trial Tr. 1624:4-17, June 19, 2019 (Hutchins) (PACT was not added as a core service despite the recommendation of the Strategic Planning and Best Practices Committee).

86. Notwithstanding the unmet need and unused capacity, PACT referrals from State Hospitals are low. JX 15 at 119, 121 (2019 DMH Budget Request: Program Performance Indicators and Measures) (showing a combined total of 23 referrals to PACT in 2017 from NMSH and SMSH); PX 151 at 10 (Mississippi State Hospital Comprehensive Strategic Plan Report Fiscal Year 2017) (showing no target established for FY 2017 referrals to PACT services, and 97 referrals for FY 2016); PX 1124 at 13-14 (FY 2018 Mississippi State Hospital Strategic Plan Report) (showing no target established for FY 2018 referrals to PACT services, and a reduction to only 70 referrals to PACT services in FY 2017); Trial Tr. 1955:16-22, June 24, 2019 (Reeves) (SMSH Clinical Director testifying that PACT referral numbers not as high as he expected); Trial Tr. 2288:23-2289:20, June 26, 2019 (Chastain) (MSH referred fewer people to PACT in FY 2017 than in FY 2016).

87. The demand for PACT is high in the State in part because of the State's chronic and sustained failure to provide appropriate community-based services. *See* Trial Tr. 610:3-9, June 10, 2019 (Byrne) (going without mental health services would cause a person's mental health to "continue to deteriorate," which then impacts the intensity of services the person will

require); Trial Tr. 844:14-845:2, June 11, 2019 (Bell-Shambley) (receipt of appropriate services over time would have lessened client need for more intensive services like PACT).

88. If Mississippi met the national average penetration rate for PACT, it would provide PACT to 1,329 adults with mental illness in a year. Trial Tr. 1537:16-1538:10, 1538:14-1539:15, June 19, 2019 (Lutterman). In FY 2018, 384 individuals received PACT in Mississippi. JX 52 at 6 (DMH FY18 Annual Report).

ii. Permanent Supported Housing

89. Though CHOICE is theoretically a statewide program, it is currently not provided in sufficient quantities to prevent unnecessary hospitalizations. As of 2018, it had been used in only about half of the counties in the state. PX 407 at 20, 23 (Peet Report); PX 416 (map of CHOICE client addresses February 2016 to January 2018); PX 979 at 8 (DMH FY17 Annual Report) (By the end of FY 2017, CHOICE was being "piloted" only in CMHC Regions 3, 4, 8, 12, and 14.); Trial Tr. 1354:20-1355:20, June 17, 2019 (Peet) (very few people currently benefitting from the CHOICE program).

90. As of January 2018, there were seven CMHC regions where fewer than five individuals had received permanent supported housing. PX 416 (map of CHOICE Program client addresses February 2016 to January 2018); *see also* Trial Tr. 701:24-702:4, June 10, 2019 (Parker).

91. Through June 2018, the CHOICE program served fewer than 350 people in total. Trial Stip. ¶ 250.

92. If Mississippi met the national average penetration rate for supported housing, it would provide supported housing to 1,899 adults with mental illness in a year.[27] Trial Tr. 1514:18-1515:3, 1539:16-1540:9, 1540:13-23, June 19, 2019 (Lutterman) (rate of supported housing in Mississippi is below the national average).

93. State Hospitals discharged some individuals to homelessness or homeless shelters instead of to permanent supported housing. JX 15 at 113, 119, 121 (2019 DMH Budget Request: Program Performance Indicators and Measures) (indicating discharge destinations after State Hospital admissions); Trial Tr. 700:13-701:5, June 10, 2019 (Parker) (Some individuals who could be referred to the CHOICE supported housing program are instead discharged from State Hospitals to homelessness; to his knowledge, there is no policy requiring State Hospitals to refer people to the CHOICE supported housing program before discharging to homelessness.); Kelly Dep. 143:3-5, May 11, 2018 ("Q: Okay. Does East Mississippi State Hospital discharge individuals directly to shelters, to homeless shelters? A: We do if they'll take them.").

iii. Community Support Services

94. The State does not provide community support services with sufficient intensity to help adults with SMI who are at serious risk of institutionalization to remain in the community and avoid repeated hospitalizations. PX 402 at 5 (VanderZwaag Report) ("[T]here was again evidence that [community support] was not implemented with the appropriate degree of frequency and penetration to impact the target population's outcomes."); PX 403 at 14 (Baldwin Report) ("There appears to be limited proactive or assertive case management efforts and, in

[27] An alternative benchmark of the statewide need for permanent supported housing can be gleaned from the findings of the Client Review Experts, who determined that approximately half of the individuals in the client review would benefit from and were appropriate for permanent supported housing. DX 328.

particular, limited proactive outreach regarding home visits."); Trial Tr. 597:20-598:17, June 10, 2019 (Byrne).

95. Data from the State's Medicaid managed care providers from FY 2017 also demonstrate that community support is not provided with sufficient intensity to prevent hospitalization. PX 373 at 3 (CMHC Billing Guidelines); PX 407 at 19-22 (Peet Report); PX 424 (Summary of Magnolia Billing Data for Community Support Services 2017) (few people receive more than 15 hours of CSS annually); PX 1006 (Berkeley Research Group Analyses for Systems Expert) (average person receiving CSS receives between 14 and 17 hours annually); Trial Tr. 1345:11-1350:25, June 17, 2019 (Peet) (Medicaid billing data indicate that people in Mississippi are not receiving community support services with the intensity that would be required to prevent hospitalization in individuals at serious risk of hospital admission.)

96. Although the State provides limited grant funding for intensive community support services, only a small number of people receive services through the grant. *See* PX 198 at 4 (DMH Intensive Community Support Services Funding Continuation Application Request) (Intensive Community Support Services Specialist is limited to a 20-person caseload); PX 262 at 3 (2011 DMH proposal for enhanced case management services throughout the State); Trial Tr. 1617:10-1618:25, June 19, 2019 (Hutchins).

iv. Supported Employment

97. As of June 30, 2018, limited DMH funding for supported employment was offered in four CMHC regions (of fourteen regions total). Trial Tr. 1595:3-1596:23, June 19, 2019 (Hutchins) (awarded grants to four CMHCs for supported employment in October 2014, distributed federal supported employment funds in December 2015).

98. As of March 28, 2019, the State had provided $40,000 grants to seven additional CMHCs to serve up to 25 individuals per region. DX 12 at 2 (Updates to Community-Based Services) (seven additional CMHC regions); Trial Tr. 1631:8-1632:19, June 19, 2019 (Hutchins) (2019 grants were for $40,000 per region and funded a single supported employment specialist with a caseload of only 20-25 individuals each).

99. Even with additional DMH funding for supported employment, the service falls well below what is necessary to serve people in or at serious risk of being institutionalized in the State Hospitals. *See* Trial Tr. 316:22-317:15, 341:14-18, June 5, 2019 (Worsham) (Despite her work as a peer support specialist and service with related statewide professional committees, Worsham had "heard that [supported employment] exists but I don't know anything about it and I don't know anyone who has ever received those services."); Trial Tr. 1630:21-1631:7, June 19, 2019 (Hutchins) (In 2011, Strategic Planning and Best Practices Committee recommended adding supported employment as a core service, yet it has not been added as a core service.).

100. If Mississippi met the national average penetration rate for supported employment, it would serve 1,266 individuals with mental illness in a given year. Trial Tr. 1515:6-21, 1558:3-12, June 19, 2019 (Lutterman) (The percent of adults with SMI receiving supported employment in Mississippi is "quite low" compared to the national average; if Mississippi provided supported employment at the national rate, in 2017 1,266 individuals would have received supported employment, but only 257 people received it that year.).

v. Peer Support

101. Peer support, though in theory offered statewide, is not provided sufficiently in all areas of the state, if it is provided at all. *See, e.g.*, Trial Tr. 138:15-20, June 4, 2019 (Drake) (testifying that in the clinical review "it was pretty rare for us to hear about somebody who was

getting much in the way of peer support services"); Trial Tr. 332:11-333:10, 339:14-23, 346:2-8, 348:1-20, June 5, 2019 (Worsham) (There are concentrations of peer support specialists in Mississippi, but they are not spread out across the state.); Kelly Dep. 110:23-111:9, May 11, 2018 (EMSH Clinical Director testifying that EMSH "need[s] more" peer support specialists).

102. In each of the three most populous regions, CMHCs billed Medicaid for peer support services for fewer than ten people in 2017.[28] PX 407 at 22 (Peet Report); PX 423 at 2 (Charts of Medicaid Billing Data); Trial Tr. 1356:16-1357:18, June 17, 2019 (Peet) (three regions billed Medicaid for almost no peer support services in 2017).

103. There are only two peer-run drop-in centers[29] in the state, despite their success. That includes the Opal Smith Drop-In Center in Gulfport and a new center in Hinds County. Trial Tr. 329:17-330:18, June 5, 2019 (Worsham) (describing effectiveness of Opal Smith Center); Trial Tr. 1592:7-20, June 19, 2019 (Hutchins) (Opal Smith Drop-In Center is in Gulfport); Trial Tr. 2206:12-22, June 26, 2019 (Crockett) (the two peer drop-in centers are effective services).

104. DMH has acknowledged a shortage of peer support services. PX 211 at 2 (Email from Andrew Day, Sept. 30, 2016) ("We need to really beef up and support peer support services more effectively."); Day Dep. 86:18-88:23, Mar. 22, 2018 (clarifying that peer support services are among those he believes "needed more attention because they . . . weren't necessarily

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[28] In addition to peer support billed directly to Medicaid, peer support may also be provided through a PACT team or through mobile crisis. *See, e.g.*, JX 60 at 107, 225 (DMH Operational Standards).

[29] A drop-in center is run by individuals with serious mental illness for others with serious mental illness. Individuals can visit a center for support, socialization, learning opportunities, and relaxation, among other things. Trial Tr. 327:12-328:2, June 5, 2019 (Worsham).

operating as effectively as they could have"); PX 473 at 11 (DMH Strategic Plan Feedback Survey 2017).

vi. Mobile Crisis Services

105. Mobile crisis response is provided unevenly across Mississippi and often without the intensity needed to prevent unnecessary State Hospital admissions.[30] PX 407 at 20-21 (Peet Report); PX 415 (2017 Mobile Crisis Calls and Contacts per 1000 Residents by CMHC Region); PX 420 (graphs of after hours mobile crisis calls and contacts and Medicaid mobile crisis calls and contacts showing regional variability); Trial Tr. 1351:1-22, June 17, 2019 (Peet) (mobile crisis teams not consistently responding to individuals in crisis in the community); Kelly Dep. 79:13-23, May 11, 2018 (EMSH Clinical Director testifying that there are insufficient crisis services available in her nine-county service area to serve everyone who needs them).

106. CMHC Region 11 has disproportionately fewer mobile crisis contacts per capita than most other regions in the state and sends more people to the State Hospitals, per capita, than most CMHCs. PX 415 (2017 Mobile Crisis Calls and Contacts per 1000 Residents by CMHC Region); PX 920 at 13 (CMHC Comparison FY 2017); *see also* PX 420 at 2 (2017 graph showing Region 11 had the lowest per capita after hours mobile crisis calls and contacts). A neighboring region, Region 8, provides about 11 times more mobile crisis responses per capita.

[30] Crisis services are so unevenly available and provided that, oftentimes, people have no choice but to jump directly to the more intense and less appropriate option of petitioning for commitment. Maddux Dep. 55:11-21, 95:17-21, May 7, 2018 (MSH clinical director stated, based on reviewing MSH admissions, that "oftentimes the person gets readmitted not because their psychiatric illness has worsened, they get readmitted because they're causing a disturbance in the community and they are identified as a former Mississippi State Hospital patient;" agreed that "there are some people who are committed by a Chancery Court that Mississippi State Hospital decided should not be admitted at all"); *see, e.g.*, PX 406 at 110-12 (Burson Report) (leading up to Person 141's admission to MSH in 2016, his mother reportedly called Region 9's mobile crisis team and "they were closed," so she called the police and petitioned to have him committed); PX 403 at 208 (Baldwin Report) (Person 117's family likely would not have needed to petition for his commitment "had a proactive 24-hour mobile crisis team, geared toward hospital diversion, been available to [them]"); *see also infra* at ¶¶119-20.

PX 415 (2017 Mobile Crisis Calls and Contacts per 1000 Residents by CMHC Region). And that region has a disproportionately low rate of State Hospital admissions: it accounts for 11.55% of the State population and 6.02% of the State Hospital admissions. PX 920 at 11, 13 (CMHC Comparison FY 2017). Region 2 also has disproportionately fewer mobile crisis contacts per capita than other regions of the State and has a disproportionately high rate of State Hospital admissions relative to its population. PX 415 (2017 Mobile Crisis Calls and Contacts per 1000 Residents by CMHC Region); PX 920 at 11 (CMHC Comparison FY 2017).

107. Some CMHCs do not respond to crises in all of the counties in their catchment area. Trial Tr. 914:19-21, 923:2-925:21, 930:18-25, June 12, 2019 (Patten) (Adams County Sheriff confirming Region 11 mobile crisis team does not serve Adams County); PX 407 at 20-21 (Peet Report); Trial Tr. 1351:23-1352:13, June 17, 2019 (Peet) (noting that it is difficult for teams to meet requirements for timely response when deployed from a single base in a CMHC region).

108. When CMHCs answer calls to their mobile crisis hotlines, they sometimes unnecessarily involve law enforcement or route the person to a hospital, rather than meeting the individual where the crisis is occurring to deescalate the situation. PX 376 at 1 (DMH Mobile Crisis Response Team Data Report) (noting 25,644 crisis calls in one year, but only 17,709 received face-to-face response); Trial Tr. 335:23-339:1, June 5, 2019 (Worsham); Trial Tr. 923:2-925:21, June 12, 2019 (Patten) (Adams County Sheriff confirming Region 11 mobile crisis team does not provide "assessments and stabilization" services in Adams County, as described in JX 52 [DMH FY18 Annual Report], and sometimes calls the Adams County Sheriff's Office to respond to a person who has called mobile crisis for help).

109. When CMHCs answer calls to their mobile crisis hotlines, they often do not connect the caller to appropriate ongoing services. *See* Hurley Dep. 96:2-10, 96:19-21, 97:6-98:9, Apr. 26, 2018 (as of mid-FY 2018, less than half the people who received mobile crisis face-to-face visits were referred to a CMHC and scheduled an appointment).

vii. Crisis Stabilization Unit Services

110. As of December 31, 2018, as well as at the time of trial, Mississippi did not have CSUs operating in all CMHC regions. JX 52 at 22 (DMH FY18 Annual Report); *see also* Trial Tr. 914:22-24, 926:24-927:14, 931:1-6, June 12, 2019 (Patten) (Adams County Sheriff confirmed there is no CSU in Adams County or Region 11, adding that he would like access to a CSU because some people in crisis "may not need to be committed" but rather "may be able to get stabilized right here at home.").

111. This is despite the State recognizing since at least 2012 that a CSU is needed in every CMHC region. PX 980 at 20 (DMH Strategic Plan FY 2012-2016); *see also* JX 26 at 9 (DMH Strategic Plan Annual Report – FY 2012) (action plan to provide a CSU in each CMHC region); Trial Tr. 1617:5-9, June 19, 2019 (Hutchins) (acknowledging the need, in 2011, to expand crisis stabilization services and that the demand for crisis services outweighed capacity in parts of the state).

112. The State has not maximized the potential to use the CSUs to divert people from State Hospitals:

a. Although the State asserts that CSUs have a high success rate at diverting adults with SMI from State Hospitals, PX 354 at 9 (DMH FY18 Fast Facts) (noting 91.85% diversion rate from the State Hospitals by CSUs), the State did not create a policy requiring referral of all

adults to CSUs for diversion from State Hospitals until late 2017.[31] Trial Tr. 1683:9-23, June 20, 2019 (Lewis) (then-DMH bureau director overseeing State Hospital facilities testified he implemented such a policy in November 2017); *see also* PX 888 (Email from Marc Lewis re FW: Adult Psychiatric Commitments/Crisis Stabilization Units). Even after it was established, key employees were unaware of this policy. *See e.g.*, Lippincott Dep. 41:6-10, Nov. 27, 2018 (NMSH Clinical Director unaware of diversion policy).

b. The State could serve more people in CSUs even with its current CSU capacity by providing oversight and technical assistance to bring the average length of stay closer to the national average. Nationally, crisis stabilization beds have a length of stay of around five days, but in Mississippi the average length of stay is about ten days.[32] Trial Stip. ¶ 213; JX 50 at 9

[31] Increasing referrals to facilities intended for rapid stabilization could prevent unnecessary institutionalization. The evidence shows that in Mississippi people often do stabilize in CSUs or local hospitals before they are admitted to a State Hospital. Dr. Joe Harris, an SMSH psychiatrist, testified at his deposition that, "A lot of where the money and inappropriateness is is [sic] some of these hospitals and doctors go ahead and send them even after the patient is better. They would save a lot of money and appropriateness if they discharge them once they're better, but they just send them on." Harris Dep. 23:9-15, Nov. 19, 2018); *see also id.* at 25:11-26:4 (Dr. Harris suggested that his treatment team at South Mississippi State Hospital do a study to track the number of inappropriate admissions after he estimated that "over half of the people that come here don't need to be here," but the treatment team ultimately decided against the study for fear of losing their jobs.); *id.* at 202:11-203:4 (some individuals have been committed at SMSH after they were already stable because the private hospital they were first admitted to "want[ed] to" continue the commitment process). Referring these people to CSUs instead would avoid these indisputably unnecessary commitments. *See* PX 404 at 16 (Drake Report) (finding that many individuals in the review population who had "short-stay admissions" to the State Hospitals "had symptoms that were resolved by the time they got to the state hospital" and that "[t]hey likely could have been treated with crisis services or in local hospitals"); Kelly Dep. 59:16-61:19, May 11, 2018 (acknowledging that some admissions to EMSH could be averted because individuals are stable on admission).

In addition, in order to reduce commitments that originate from local hospitals, the State could, but does not, provide grant funding to those hospitals to care for people even after the money "runs out." *See* PX 182 (Adult Community Services grants) (showing no grants to local hospitals); Trial Tr. 1673:25-1674:3, June 20, 2019 (Lewis). And if the State provided more community-based services, the need for hospitalizations would decrease. Mikula Dep. 12:24-13:6, Mar. 28, 2019.

[32] It is possible to provide CSU services with shorter lengths of stay in Mississippi. Dr. Crockett testified that in the limited time that the Region 9 CSU has been operational, the average length of stay was three to seven days. Trial Tr. 2231:25-2232:3, June 26, 2019 (Crockett).

(DMH Strategic Plan FY18 End-of-Year Progress Report) (CSU average length of stay is 10.71 days); PX 407 at 12 (Peet Report).

2. Many People Are Committed to State Hospitals Because They Do Not Have Access to Appropriate Community-Based Services.

113. Individuals who are appropriate for community-based treatment are hospitalized in Mississippi because they do not have access to, or do not receive, services that prevent unnecessary hospitalization. PX 403 at 2, 14 (Baldwin Report); PX 404 at 20-21 (Drake Report); Trial Tr. 105: 8-18, June 4, 2019 (Drake) (testifying that the patients in this review did not receive many of the community-based services as described in the DMH's operational standards); Trial Tr. 352:15-353:1, June 5, 2019 (Worsham) (testifying that an increased number of crisis responses alone is not progress: "[C]hances are a large majority of those people did not need crisis services had peer support or other recovery-oriented providers been available. I think it's sad that that many people go into crisis and need that kind of help when they might have been – it could have been prevented."); Trial Tr. 394:7-17, June 6, 2019 (VanderZwaag) (all 28 people whom the expert reviewed "were in need of more comprehensive outpatient services."); Trial Tr. 735:15-18, 741:2-6, June 11, 2019 (H.B.) (daughter was not receiving any community-based mental health services before her January 2014 commitment that lasted over four years); Trial Tr. 965:8-15, June 12, 2019 (Baldwin) (individuals had many readmissions to State Hospitals because of "a dearth of community-based services in between those admissions," which led to worsening of symptoms); Day Dep. 99:23-100:6, Mar. 22, 2018 (it is critical for people to receive community treatment before they become so acutely ill that they need hospitalization); Kelly Dep. 63:22-64:8, May 11, 2018 (EMSH Clinical Director testifying that people are "often" admitted to the hospital, even repeatedly, who are appropriate for community-based services, but are not connected in any way to such services).

114. For example, people who required PACT services in order to avoid hospitalization did not receive PACT services. Trial Tr. 415:20-416:6, 449:21-25, June 6, 2019 (VanderZwaag) (PACT would have improved Person 46's tenure in the community, but it is not available where he lives); Trial Tr. 591:20-595:21, June 10, 2019 (Byrne); Trial Tr. 820:18-821:25, 833:9-20, 843:8-845:7, June 11, 2019 (Bell-Shambley) (recommending PACT for Persons 3 and 18, and noting PACT is not available in Region 7 where they live).

115. Indeed, some individuals whom the State Hospital recognized needed PACT services could not receive PACT, because PACT did not exist in their home counties. *See, e.g.,* Trial Tr. 404:4-6, June 6, 2019 (VanderZwaag) (PACT not available in Person 52's home county); Trial Tr. 450:1-8, June 6, 2019) (VanderZwaag) (same for Person 49); PX 401 at 67; 86 (Byrne Report); PX 402 at 59 (VanderZwaag Report); PX 281 (PACT Team Tracking Form) (form includes a column, with many people listed in it, for "meet criteria but no PACT team in area").

116. Of the 154 individuals in the review population, the United States' experts concluded that 100 individuals were appropriate for and would benefit from PACT, but more than half of those individuals live in a county or region where PACT was not available as of June 30, 2018. PX 417 (map of client review members with PACT recommendations and PACT team locations).

117. Although community support services are available in all regions, they are not provided with the intensity and frequency required to avoid hospitalization. *See, e.g.,*PX 403 at 207-09 (Baldwin Report) (person could have avoided or spent less time in the State Hospital if provided appropriate services in the community); PX 406 at 106 (Burson Report) (person from client review sample who has received "minimal" community services "in both frequency and

potency, especially given her frequent hospitalizations"); PX 408 at 73-75 (Bell-Shambley Report) (person from client review who is actively engaged in services with a CMHC but who might have avoided his most recent hospitalization if provided higher intensity services such as mobile crisis and in-home interventions; Trial Tr. 837:3-845:25, June 11, 2019 (Bell-Shambley) (Person 18 was hospitalized twice in 2017 because the community support services she was receiving failed to increase in intensity as her needs increased and failed to address known stressors that aggravate her symptoms and that could have been addressed with additional services like mobile crisis and permanent supported housing).

118. In addition, permanent supported housing is not provided to those who need it to avoid unnecessary State Hospital admissions. Trial Tr. 845:8-25, June 11, 2019 (Bell-Shambley) (recommending PSH for Person 18 from the client review because her living situation, with her mother, is a source of stress for her, resulting in a worsening of symptoms of her illness); Trial Tr. 1087:10-1089:2, June 12, 2019 (Burson) (Although Person 125's discharge summary stated he "has become paranoid with his family," which "has caused him worry and agitation, leading to decreased sleep, et cetera, and racing thoughts, poor concentration and hyperactivity," he was discharged from SMSH to the same home.). *See also* Trial Tr. 785:20-23, 786:7-787:2, June 11, 2019 (C.R.) (T.M. wants to and would be able to live in his own apartment with community-based services, but C.R. had not been informed about permanent supported housing.).

119. Similarly, people who required crisis services did not receive crisis services as an alternative to hospitalization. *See, e.g.,* PX 401 at 8-10, 39, 60 (Byrne Report); PX 402 at 7 (VanderZwaag Report); PX 403 at 99, 208 (Baldwin Report); Trial Tr. 792:21-794:20, 796:2-7, June 11, 2019 (C.R.) (Mobile crisis was not called when T.M. was hospitalized in a local

hospital after experiencing T.M.'s worst symptoms that C.R. had seen.); Trial Tr. 988:18-997:13, 999:5-1001:14, June 12, 2019 (Baldwin) (Person 117, Person 108).

120. Frequently, individuals and their family members were not aware of mobile crisis services. PX 403 at 203 (Baldwin Report); PX 406 at 66, 112 (Burson Report); Trial Tr. 784:20-785:12, June 11, 2019 (C.R.) (C.R. had never been informed about crisis services in the community to assist T.M. if his symptoms started to increase but would prefer community-based crisis services to T.M. being hospitalized); Trial Tr. 990:1-14, June 12, 2019 (Baldwin).

121. Individuals who needed supported employment to avoid hospitalization were also not receiving this service. Trial Tr. 151:4-11, June 4, 2019 (Drake) (while "many people in the sample wanted to work," "only a small number of them had gotten supported employment services"); Trial Tr. 432:23-439:12, June 6, 2019 (VanderZwaag) (Person 49 was not receiving supported employment and other recovery-oriented services, putting him at serious risk of further institutionalization and contributing to his "sense of hopelessness, feeling like services are not useful to him"); Trial Tr. 1083:7-1084:15, 1085:20-1086:1, June 12, 2019 (Burson) (no one in the review whom Ms. Burson recommended for supported employment was actually receiving it); PX 406 at 5 (Burson Report).

3. State Hospital Discharge Planning is Inadequate.

122. Discharge planning at the State Hospitals is inadequate to prevent avoidable State Hospital re-admissions.

123. Discharge planning in Mississippi's State Hospitals does not begin at the time of admission. PX 403 at 19 (Baldwin report); Trial Tr. 1001:23-1002:11, 1002:22-1003:5, June 12, 2019 (Baldwin) (discharge planning was inadequate; in particular "discharge planning [did not take] place right at the point of admission, which is standard practice").

124. Overwhelmingly, discharge planning in Mississippi does not involve coordination between the State Hospitals and CMHCs prior to discharge.[33] PX 151 at 9 (Mississippi State Hospital Comprehensive Strategic Plan Report Fiscal Year 2017) (20% of patients met with a CMHC representative before discharge in FY 2016); PX 403 at 18-19 (Baldwin Report); PX 404 at 22 (Drake Report); PX 407 at 26-28 (Peet Report); PX 1124 at 11 (FY 2018 Mississippi State Hospital Strategic Plan Report) (20% of patients met with a CMHC representative prior to discharge in FY 2017); Trial Tr. 625:14-19, June 10, 2019 (Byrne); Trial Tr. 818:5-819:20, June 11, 2019 (Bell-Shambley); Trial Tr. 1001:23-1002:21, June 12, 2019 (Baldwin); Trial Tr., 1369:6-1370:2, June 17, 2019 (Peet); Trial Tr. 2272:21-2274:5, June 26, 2019 (Chastain) (despite goal of increasing percentage of patients visited by a CMHC prior to discharge, percentage did not change between FY 2016 and FY 2017); Carlisle Dep. 151:11-20, 152:18-153:7, June 15, 2018 (describing EMSH's responsibility for coordinating with CMHCs as follows: "to get them in contact with the [CMHC] as a good, you know, here they are. You know, we've stabilized them, this is the medication that they're on."); Fleming Dep. 33:5-19, Apr. 11, 2018; Kelly Dep. 132:2-11, 135:1-4, May 11, 2018; Newbaker Dep. 182:12-183:5, Apr. 12, 2018; Pounds[34] Dep. 126:12-15; 127:4-8; 149:24-150:4, May 8, 2018.

125. State Hospital discharge planning does not include assisting with securing income and health insurance, which decrease the likelihood of re-admission. PX 403 at 11, 40, 42, 196,

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[33] While the Director of MSH testified that "[o]ur social work staff are making calls or at least attempting to call people seven days after discharge[,] [a]nd then I believe they make another phone call 30 days after discharge," Trial Tr. 2297:3-9, June 26, 2019 (Chastain), his testimony is not credible in light of the testimony of MSH's Social Services Director, who stated that no calls are made after discharge because "the responsibility of the care becomes the Community Mental Health Center." Fleming Dep. 7:25-8:8, 13:18-14:5, Apr. 11, 2018 (as Social Services Director, Fleming supervises the social workers who conduct discharge planning); *see also* Trial Tr. 2299:12-23, June 26, 2019 (Chastain).

[34] Angela Pounds is Social Work Director of SMSH. Pounds Dep. 7:21-22, 8:13-15, May 8, 2018.

205, 207-08 (Baldwin Report); Trial Tr. 993:24-995:5, 998:13-999:4, June 12, 2019 (Baldwin) (benefits assistance not provided to individuals reviewed by Dr. Baldwin); Newbaker Dep. 228:18-230:3, Apr. 12, 2018.

126. State Hospital discharge planning was not adjusted if and when an individual was readmitted to a State Hospital. PX 403 at 42-43 (Baldwin Report); PX 406 at 137 (Burson Report); PX 1099 (Person 3's first EMSH discharge summary); PX 1100 (Person 3's second EMSH discharge summary); PX 1101 (Person 3's third EMSH discharge summary); Trial Tr. 822:1-833:12, June 11, 2019 (Bell-Shambley) (Person 3 had three hospitalizations in two years and discharge plans were the same each time); Trial Tr. 1003:20-1006:4, June 12, 2019 (Baldwin) (Person 92 did not receive adequate discharge planning, including being discharged to an exploitative and abusive relative, which caused her to cycle into the State Hospital six times); Trial Tr. 1090:10-1097:17, 1151:3-1155:18, June 12, 2019 (Burson) (discharge planning was "formulaic" in that "[p]eople pretty much got the same discharge plan," and it did not change "even when in the past the discharge plan hadn't worked.").

127. Discharge planning does not adequately ensure continuity of medications. PX 77 at 82; Trial Tr. 1961:8-1962:13, June 24, 2019 (Reeves) (less than five percent of individuals receive even a four-day supply of medication on discharge, despite risks if an individual cannot fill their prescription after four days);[35] Trial Tr. 2213:10-25, June 26, 2019 (Crockett) (describing issues with medications on discharge). *See also* Trial Tr. 448:1-13, June 6, 2019 (VanderZwaag) ("Typically," on discharge, a state hospital "will give the individual a supply of

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[35] Dr. Reeves was unaware that for at least one person he offered an opinion on, Person 53, that risk was realized. Trial Tr. 1975:11-1976:2, June 24, 2019 (Reeves); PX 402 at 92 (VanderZwaag Report) (Person 53 was unable to obtain medication after discharge).

medication to take with them, hopefully enough to get to the first appointment with a prescriber;" per her review, this did not occur in Mississippi.).

128. Discharge planning often does not include connecting people to services that actually do exist.

a. For example, the State Hospitals make minimal referrals to the CHOICE program. Trial Tr. 396:2-23, June 6, 2019 (VanderZwaag) (instead of referring to CHOICE, the State Hospitals refer people who have struggled in the community "to the institution of a personal care home, even if they don't want to" live in that setting); Trial Tr. 693:5-18, 699:5-700:22, June 10, 2019 (Parker) (State Hospitals are going long periods without referring individuals to CHOICE and are instead discharging individuals to homelessness.); Newbaker Dep. 56:24-58:7 (EMSH Social Services Director is "not aware" whether EMSH is referring individuals to CHOICE.). This occurs even as State Hospital employees lament the need for housing options. Harris Dep. 26:11-17, Nov. 19, 2018 ("Our biggest problem is not having places to send them to. It's the housing problem that's our biggest problem."); Maddux Dep. 149:2-150:8, May 7, 2018 ("Q: Would more permanent supported housing enable people to be discharged faster? A: In my opinion, it would."); Newbaker Dep. 126:1-8, April 12, 2018 ("I believe we could benefit from more – from more housing for homeless, certainly"); *see also* PX 366 at 26-27 (MPA Report, 2010) (noting the dearth of supported housing options, while people with SMI "liv[e] in deplorable conditions in personal care homes[36] around the state").

[36] Some Personal Care Homes are licensed by the Department of Health. Miss. Dep't of Health, "Minimum Standards for Personal Care Homes," https://msdh.ms.gov/msdhsite/_static/resources/342.pdf. Staff may, but are not required, to provide assistance with grooming and dressing. *Id.* Personal care homes do not provide medical or psychiatric care for their residents, with the exception of assisted living homes that provide "medication procedures and medication administration." *Id.* Licensed Personal Care Homes range in size from 2-100 beds. *See Directory of Mississippi Health Care Facilities* 71 (July 2018), https://msdh.ms.gov/msdhsite/_static/resources/7660.pdf.

b. The State Hospitals also make minimal referrals to PACT, despite treating many individuals who are eligible for the service. *Compare* PX 151 at 10 (Mississippi State Hospital Comprehensive Strategic Plan Report Fiscal Year 2017) (97 total patients in FY 2016 were referred to PACT on discharge if available in the area they live) *with* PX 1124 at 13 (FY 2018 Mississippi State Hospital Strategic Plan Report) (70 total patients in FY 2017 were referred to PACT on discharge if available in the area they live, though the goal was to increase the number of patients referred to PACT).

129. Discharge planning generally does not include the individual and the individual's family or others responsible for the person's care. Trial Tr. 779:3-19, June 11, 2019 (C.R.) (C.R. only learned her cousin was in the State Hospital when the State Hospital social worker called and asked C.R. what T.M.'s discharge plan was, and the State Hospital has never called her to discuss what events precipitate T.M.'s admissions); Trial Tr. 824:20-826:24, 828:11-14, 831:1-5, June 11, 2019 (Bell-Shambley) (The documentation about Person 3's transition planning did "not indicate coordination with the community provider or the engagement with the family."); Trial Tr. 1001:23-1002:7, June 12, 2019 (Baldwin) ("I did not see the inclusion of the individual or their informal support network involved in discharge planning as much as . . . I thought it should be, given my experience."); *see also* Trial Tr. 386:1-387:16, June 6, 2019 (VanderZwaag) (hospital treatment team created its own goals for discharge criteria that did not address Person 50's preferences or symptoms).

The Court may take judicial notice of publicly available documents produced by a state agency. *Planned Parenthood Gulf Coast, Inc. v. Kliebert*, 141 F. Supp. 3d 604, 645-46 & n.34 (M.D. La. 2015) (quoting *Funk v. Stryker Corp.*, 631 F.3d 777, 783 (5th Cir. 2011); *see also Committee to Protect our Agricultural Water v. Occidental Oil & Gas Corp.*, 235 F. Supp. 3d 1132, 1153 (E.D. Cal. 2017).

130. State Hospitals impose inappropriate discharge criteria that are not linked to whether the person can be served in an integrated, community-based setting. PX 403 at 18 (Baldwin Report) ("There were also instances in which patients articulated the type of community setting in which they would like to live and were told by hospital staff that the option would not be possible for them, because they were not capable of living in that type of setting, which was untrue."); Trial Tr. 440:7-23, June 6, 2019 (VanderZwaag) (people had unnecessarily extended stays at State Hospitals because treatment teams set unrealistic goals or goals inconsistent with person's desires). For example, State Hospital progress notes for Person 91 indicated "no evidence of exacerbation of serious mental illness symptoms" and indicated that State Hospital treatment staff saw Person 91's desires to leave the hospital and be more independent as evidence that he was not ready to leave. Trial Tr. 1009:16-1015:9, June 12, 2019 (Baldwin); PX 403 at 31 (Baldwin Report); PX 1110 (MSH Clinical Progress Notes) (Person 91 "continues to have limited insight and awareness into his condition AEB stating 'I don't know why they put me here! I'm just ready to leave here! This like prison!'"); PX 1111 (MSH Clinical Progress Notes) (Person 91 asked his social worker each day about going home but was told "he's not quite ready for discharge"); PX 1112 (MSH Clinical Progress Notes) (MSH social worker found Person 91's request for shoes to walk on his stumps as "an indicator that he was not ready to leave").

131. Individuals who are appropriate for discharge are nonetheless unnecessarily held at the hospital past that time, because discharges are scheduled at the hospital's convenience rather than being based on the person's needs. PX 880 at 1 (EMSH Social Services Minutes Aug. 6, 2014) (discharges are only permitted Monday through Thursday, except from the

chemical dependency unit, a unit not at issue in this case, which can discharge on Friday "because they have an admission to replace the discharge immediately").

4. *Many Hospitalizations Are Unnecessarily Long Due to the Unavailability of Community-Based Services and the Lack of Effective Discharge Planning.*

132. Inadequate discharge planning leads to prolonged hospital stays. PX 403 at 18-19, 22 (Baldwin Report); Trial Tr. 976:17-978:17, June 12, 2019 (Baldwin) (MSH determined Person 90 did not meet the criteria for admission on October 13, 2016, days after she entered the hospital, but was not discharged until the third week of January 2017.); Trial Tr. 979:21-980:24, June 12, 2019 (Baldwin) (Person 104 stabilized quickly but was not discharged, and "the window [for discharge] was missed"); Trial Tr. 441:24-443:23, June 6, 2019 (VanderZwaag) (Person 50 had been at MSH three years but was appropriate for the community.).

133. Inadequate community-based services result in prolonged hospital stays. PX 60 at 3-4 (Utilization Review Committee Minutes, May 28, 2016) (Utilization Review Committee recommending continued treatment at MSH because alternative placements not available); PX 402 at 30 (VanderZwaag Report) (Person 34 had been awaiting community placement for over a year.); Trial Tr. 741:2-6, June 11, 2019 (H.B.) (his daughter was in MSH for more than four years because there was no appropriate community placement for her); Trial Tr. 979:21-980:8, June 12, 2019 (Baldwin) (Person 104 stabilized within one week of her admission to the State Hospital, but she stayed there because of problems finding housing.); Newbaker Dep. 36:21-37:10, Apr. 12, 2018 (it is sometimes difficult to find a place to discharge individuals even after they no longer meet the commitment criteria).

134. In fact, the Medical Director of DMH admitted that people discharged from Mississippi State Hospital's continued treatment unit in May 2018 could have been discharged

months before. JX 37 at 1-6 (MSH B45 and B39 Potential Candidates for Group Home) (listing 41 candidates for group homes, including Person 19, Person 21, Person 25, Person 50, Person 52, Person 54, Person 57, Person 79, and Person 109); Maddux Dep. 29:15-24, 30:24-31:1, 32:19-25, 46:24-47:3, 47:15-19, May 7, 2018. He also admitted that "it's quite frequent" that someone remains in a State Hospital because discharge destination has not been identified, Maddux Dep. 147:11-15, May 7, 2018, and that more services would enable shorter stays. Maddux Dep. 148:21-23, 149:2-150:8, May 7, 2018; *see also* Kelly Dep. 97:23-98:3, May 11, 2018; Lippincott Dep. 35:9-12, Nov. 27, 2018; Mikula Dep. 223:10-23, Mar. 28, 2019 (DMH has no plans to open additional community transition homes[37]).

5. *People Remain at Serious Risk of Hospitalization After Discharge Because They Are Not Connected to Community-Based Services Known to Reduce Hospitalization.*

135. When individuals are discharged from State Hospitals, many are at serious risk of re-institutionalization both because of poor discharge planning and because they are returning to the same absence of services that precipitated the commitment. *See, e.g.,* PX 403 at 14, 18-19, 233 (Baldwin Report); PX 406 at 5 (Burson Report); Trial Tr. 955:12-22, 1003:6-19, June 12, 2019 (Baldwin) (individuals were at serious risk because they were discharged to a lack of community-based services and "the same situation . . . over and over again"); Trial Tr. 1081:2-13, June 12, 2019 (Burson) (services were unavailable; services were available, "but for whatever reason," were "either not considered or not prescribed"; or services were not provided "with the intensity or the frequency that would mitigate the risk.").

[37] In 2018, Mississippi funded three community transition homes for people transitioning from MSH's continued treatment unit. JX 52 at 11; Trial Tr. 2197:17-2198:10, June 26, 2019 (Crockett); Trial Tr. 2265:10-19, June 26, 2019 (Chastain). The homes are staffed at all hours. DX 12 at 1 (Updates to Community-Based Services). Individuals living in those homes pay their own rent. *Id.*

136. Of the representative sample of 154 individuals, 104 of the 122 individuals who were not in a psychiatric unit at the time of their interview were at serious risk of returning to a State Hospital because they were not receiving appropriate mental health services. PX 405 at 5 (MacKenzie Report).

137. For example:

a. Person 3: PX 408 at 20, 22 (Bell-Shambley Report); Trial Tr. 822:1-834:1, June 11, 2019 (Bell-Shambley) (Person 3 is at serious risk and experiencing severe symptoms of his mental illness, in part, because EMSH did not effectively transition him from inpatient to community-based services, even after multiple admissions);

b. Person 117: PX 403 at 207-09 (Baldwin Report); PX 1109 (discharge summary for Person 117); Trial Tr. 991:8-993:9, 995:6-24, June 12, 2019 (Baldwin) (discharge planning for Person 117 was inadequate and placed him at serious risk of re-hospitalization);

c. Persons 49: PX 402 at 80 (VanderZwaag Report); Trial Tr. 447:1-23, June 6, 2019 (VanderZwaag) (Person 49 was re-hospitalized relatively quickly as a result of not having access to medication on discharge);

d. Person 140: PX 406 at 118, 120 (Burson Report) (Person 140 had been hospitalized at East Mississippi State Hospital eight times without receiving PACT or other intensive services); and

e. Person 58: PX 401 at 23-25 (Byrne Report); Trial Tr. 591:16-596:8, June 10, 2019 (Byrne) (Person 58 was hospitalized five times in two years because she “had a history of being nonadherent with her medications” and received no mental health services between admissions, despite living in a county with a PACT team).

138. A related failure was that State Hospitals did not refer people to PACT even when it could have been available to them. *See, e.g.*, PX 401 at 129 (Byrne Report); Trial Tr. 625:20-630:25, June 10, 2019 (Byrne) (Person 89 had three State Hospital admissions within one year, yet MSH never referred him to a PACT team despite discharging him to Regions 9 and 15, which have PACT teams; his three discharge plans were substantively the same and "[n]ot clinically appropriate," given the lack of involvement of any community-based treatment team and the failure to refer him to appropriate services); *see also supra* ¶ 128 (describing a similar failure to refer to CHOICE).

E. The Opinions of the State's Experts Are Non-Responsive to the United States' Claim and Not Persuasive.

139. The opinions of the State's Clinical Experts[38] do not contravene the United States' evidence that many State Hospital admissions are avoidable. Further, the State's Clinical Experts' opinions are based on an unreliable methodology.

a. The State's Clinical Experts only considered whether individuals' symptoms at the time of commitment justified that commitment. *See, e.g.*, Trial Tr. 1842:10-1846:11, June 24, 2019 (Webb); Trial Tr. 1878:7, June 24, 2019 (Root); Trial Tr. 1950:18-1951:2, June 24, 2019 (Reeves); Trial Tr. 2129:11-14, June 25, 2019 (Younger); Trial Tr. 2167:18-2168:13, June 26, 2019 (Wilkerson).

b. The State's Clinical Experts did not even consider, let alone answer, the pivotal question in the case: whether individuals were or could have been receiving community-based

[38] Dr. Roy Reeves, Dr. Charles Lippincott, Dr. William Wilkerson, Dr. Susan Younger, Dr. Benjamin Root, Dr. Mark Webb, and Dr. Philip Merideth are the State's Clinical Experts.

services known to reduce the need for hospitalization.[39] *See, e.g.*, Trial Tr. 1840:21-1842:3, 1846:12-22, June 24, 2019 (Webb); Trial Tr. 1877:22-1878:1, June 24, 2019 (Root) Trial Tr. 1920:19-24, June 24, 2019 (Lippincott); Trial Tr. 1951:18-1952:14, June 24, 2019 (Reeves); Trial Tr. 2015:16-23, June 25, 2019 (Merideth); Trial Tr. 2129:22-2131:8, June 25, 2019 (Younger); Trial Tr. 2181:8-24, June 26, 2019 (Wilkerson).

c. In forming their expert opinions, the doctors did not interview the individuals about whom they opined, nor did they interview any family members or community service providers. Trial Tr. 1847:13-1850:8, June 24, 2019 (Webb); Trial Tr. 1890:10-1891:20, June 24, 2019 (Root); Trial Tr. 1922:6-1923:9, June 24, 2019 (Lippincott); Trial Tr. 1949:21-1950:13, 1954:7-9, June 24, 2019 (Reeves); Trial Tr. 2016:8-25, June 25, 2019 (Merideth); Trial Tr. 2116:24-2117:4, 2117:9-17, June 25, 2019 (Younger); Trial Tr. 2168:14-2170:25, June 26, 2019 (Wilkerson); *see also* Trial Tr. 1988:24-1989:8, June 25, 2019 (Merideth) ("[I]t's always nice to be able to have a face-to-face opportunity and evaluation in a case, and I should say in most -- in many cases it is. In this case, I was not asked to do so.").

d. Drs. Reeves and Lippincott merely reviewed their own care.[40] Trial Tr. 1920:25-1924:25, June 24, 2019 (Lippincott); Trial Tr. 1949:21-1950:13, 1954:7-9, June 24, 2019 (Reeves).

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[39] These physicians ignore or overlook the importance of recovery-oriented, person-centered services in the context of mental health. As Melody Worsham explained at trial, a recovery-oriented viewpoint is critical because it empowers individuals with mental illness to "live the fullest life that [they] can possibly live based on [their] strengths and [their] own goals is the best that can be offered." Trial Tr. 341:19-342:16, June 5, 2019 (Worsham). When services are recovery-oriented, they are more successful. Trial Tr. 430:18-431:5, June 6, 2019 (VanderZwaag).

[40] The judgments of the State's treating professionals were not all reasonable and are not entitled to deference. *See, e.g.*, *supra* ¶ 130 (discussing Person 91); *see also* Trial Tr. 382:20-385:22, 441:19-444:16, June 6, 2019 (VanderZwaag) (the treatment team was waiting for Person 50 to have insight into her mental illness and verbalize that she would take medicines as an outpatient).

140. As further evidence of the limited scope of their review, the State's clinical experts did not know basic facts about the individuals in their reports. *E.g.*, *compare* Trial Tr. 1829:21-1830:7, 1830:17-20, June 24, 2019 (Webb) (testifying that Person 96 had threatened his mother in 2016 as part of opinion that 2016 State Hospital admission was appropriate) *with* PX 403 at 67 (Baldwin Report) (noting that Person 96's mother died in 2003); Trial Tr. 1975:11 – 1976:2, June 24, 2019 (Reeves) (testified at deposition that Person 53 had access to medication; unaware that Person 53 told Dr. VanderZwaag that she had no insurance and no income, and was unable to get medication after discharge); Trial Tr. 2177:25-2180:10, June 26, 2019 (Wilkerson) (at deposition stated that the United States' expert's statement on Person 25 that she "would benefit from community-based services flies in the face of the fact that everyone else who has been associated with this patient closely and for years at a time doesn't agree;" was unaware of her placement in the community three months prior, in September 2018).

VI. Individuals with Serious Mental Illness in Mississippi Do Not Oppose Receiving Services in the Community.

141. With few exceptions, adults with serious mental illness in Mississippi do not oppose receiving services in the community rather than in State Hospitals. *See, e.g.*, PX 405 at 5 (MacKenzie Report) (149 of the 150 living individuals in the Clinical Review did not oppose receiving services in the community); PX 1102 (letter from T.M.); Trial Tr. 779:22-780:2, 780:23-782:19, 787:17-20, 788:19-789:1, 791:14-20, June 11, 2019 (C.R.) (T.M. "wanted to be released" when he was in the State Hospital and sent a letter in which T.M. planned for when he got "released" from the State Hospital); Trial Tr. 966:10-21, June 12, 2019 (Baldwin) (individuals in the clinical review had negative experiences in the State Hospital, and for one woman it was "the most humiliating experience she had ever had in her life"); Trial Tr. 1331:18-

1332:12, June 17, 2019 (Peet) ("The great majority of people with serious mental illness would prefer to receive services in the community where they are living.").

142. The State acknowledges that adults with serious mental illness typically prefer to receive community-based mental health services, rather than treatment in a State Hospital. Day Dep. 164:11-22, Mar. 22, 2018; Vaughn Dep. 29:16-19, 29:20-30:9, Mar. 29, 2018 (testifying that if a person had to choose between living in the community or living in an institution, she "would expect them to choose the community" because there is more freedom and "it's not ideal to live in a hospital").

143. Family members of individuals with serious mental illness who have experienced State Hospital admissions testified that they would prefer that their family members be served in the community. Trial Tr. 728:16-729:6, 734:6-735:21, 737:23-738:9, 755:20-22, June 11, 2019 (H.B.) (testifying that he never wanted anyone he loved to go to a State Hospital and that it was difficult for him to file a commitment for her but that he "didn't have any other choices); Trial Tr. 784:25-785:19, June 11, 2019 (C.R.) ("No family member wants a person they care about to be in an institutional setting. To the extent that they can be -- receive services and what is required for them to exist in the community amongst family, then I think that any family member would prefer that.").

144. People rarely, if ever, make an informed choice to live in State Hospitals. Trial Tr. 814:17-23, June 11, 2019 (Bell-Shambley) ("[B]ased on having worked for 30 plus years with individuals who are recipients of mental health services, I have not come across anyone who desired to receive services or live in a hospital setting if other appropriate settings were available to them. And I doubt that there is anyone who would make the choice, an informed choice, to live in a hospital setting."); *see also* Trial Tr. 509:24-510:2, June 6, 2019

(VanderZwaag) ("[I]t's no life to be in a hospital …. [I]t's being alive, but that's different from having a life.").

145. It is unsurprising that individuals do not wish to receive services in a State Hospital, given the restrictive conditions there. Policies at the State Hospitals in Mississippi requiring patients to wear armbands identifying their privilege levels, earn the privilege of wearing their wedding rings, and undergo full body searches on admission highlight the lack of freedom and dignity associated with a State Hospital admission. PX 407 at 15 (Peet Report); Trial Tr. 1332:13-1333:2, June 17, 2019 (Peet) (identifying these policies as unusual and excessive).

146. Furthermore, at the time they were interviewed, 122 of the 150 living individuals in the clinical review sample were not in a State Hospital. *See* PX 405 at 5 (MacKenzie Report); PX 406 at 8 (Burson Report) (noting reviewers did not make at risk determinations for people who were in the hospitals). These individuals are appropriate for, and do not oppose, receiving treatment in the community—facts that the State essentially conceded when it discharged them from a State Hospital to the community.

VII. The State Can Make Reasonable Modifications to Its Service System to Avoid Unnecessary Institutionalization and Those Modifications Do Not Constitute a Fundamental Alteration.

A. It Is a Reasonable Modification and Not a Fundamental Alteration for the State to Expand Community-Based Services and Provide Them to People Who Are in the State Hospitals and at Serious Risk of State Hospital Admission.

1. It Is Reasonable to Require Statewide Availability of Services the State Agrees Are Effective at Reducing Hospitalizations.

147. The services that can remedy this violation are services that already exist, in patchwork fashion, in Mississippi and are services that the State has endorsed. *See supra* § IV.A. *See also* PX 407 at 9, 19-24 (Peet Report); Trial Tr. 1379:10-17, June 17, 2019 (Peet); Trial Tr.

2233:24-2234:4, June 26, 2019 (Crockett) ("Region 9 has had an opportunity to expand services over the last several years, and we want to continue to be able to do that, and even enhance some of our existing services.").

148. It is possible for the State to provide community-based services to those who need them throughout the State. *See* Trial Tr. 186:15-187:12, June 5, 2019 (Drake) (other states, unlike Mississippi, have moved beyond the "first phase of deinstitutionalization" by implementing community-based services system-wide, which in turn led to reduced use of psychiatric hospitals); Trial Tr. 943:25-944:20, 946:11-947:10, 983:14-985:25, June 12, 2019 (Baldwin) (Massachusetts developed community-based services in the 1970s and 1980s during the "process of deinstitutionalization" from State Hospitals); PX 403 at 3-4 (Baldwin Report); Trial Tr. 1452:12-22, June 17, 2019 (Peet) (as deputy commissioner in Connecticut ensured that each of the necessary services was available in every local mental health region); *see also* PX 1078 at 63 (SAMHSA ACT Toolkit) ("ACT programs have been implemented throughout the United States as well as in Canada, England, Sweden, Australia, and the Netherlands, and they operate in both urban and rural settings.").

149. The State acknowledges that statewide availability of community-based services will prevent unnecessary hospitalization. PX 23 (describing the need to expand "evidenced-based programs such as PACT [that] are essential to keep[ing] individuals in the community"); Trial Tr. 1615:21-1618:25, June 19, 2019 (Hutchins) (agreeing that "it's important to ensure access to community-based services like PACT across Mississippi"); Trial Tr. 2055:1-3, June 26, 2019 (Allen) (DMH funds a mobile crisis team in every county because they reduce reliance on state hospitals); Allen Dep. 42:16-43:21, 137:12-23, June 14, 2018 (it is "[v]ery accomplishable" to reduce State Hospital admissions by increasing CSU beds, which can enable people to

"receive the same care and same intervention . . . in their own community" and usually involve a shorter length of stay).

150. Expanding existing services aligns with the State's stated policy goals. *See, e.g.*, JX 53 at 11-15 (DMH FY 2019-FY 2021 Strategic Plan) (goals, objectives, and strategies to increase various community-based services); PX 457 at 4 (DMH FY11 Annual Report) (envisioning "a better tomorrow" where "[a]ll Mississippians have equal access to quality mental health care, services and supports in their communities[]"); PX 438 at 3 (DMH FY15 Annual Report) ("We believe that community-based service and support options should be available and easily accessible in the communities where people live."); PX 801 (January 5, 2016 email from Jake Hutchins to Diana Mikula) (DMH official states, "We would like to have all the CMHC's offer supported employment.").

2. *It Is Reasonable to Require Statewide Availability of Services Where the State is Already Obligated To Do So Under Medicaid Rules.*

151. When a state participates in the Medicaid program and includes services in its State Medicaid Plan, as Mississippi has done here, it is obligated to ensure that those services are available with reasonable promptness to all Medicaid beneficiaries who meet the eligibility criteria statewide. 42 U.S.C. § 1396a(a)(8), 42 C.F.R. § 435.930 (with reasonable promptness); 42 U.S.C. § 1396a(a)(1), 42 C.F.R. § 431.50 (statewide); *see also* Toten[41] Dep. 77:12-23, 213:2-9, May 23, 2018 (Mississippi Division of Medicaid is obligated to ensure statewide availability of services included in the State Medicaid Plan).

152. Mobile crisis, crisis stabilization services, PACT, community support services, and peer support are all included in Mississippi's State Medicaid Plan. *See supra* ¶ 22; *see also*

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[41] Charlene Toten is a Bureau Director in DOM's Office of Mental Health, Toten Dep. 5:9-18, May 23, 2018, where she oversees CMHCs. *Id.* at 8:13-25.

Toten Dep. 194:8-15, May 23, 2018 (Medicaid would reimburse for additional people to receive PACT). Non-emergency medical transportation is also available to Medicaid beneficiaries. *See* JX 4 at 6 (MAC Plan Update, May 12, 2016 Draft).

153. While there are service limits for services under the Medicaid fee-for-service program,[42] managed care companies can exceed those limits. PX 373 (DOM Fee Schedule for CMHCs July 1, 2017); PX 407 at 7 (Peet Report); Trial Tr. 1330:3-21, June 17, 2019 (Peet) (there are hard caps on the number of units of service available under the Medicaid fee-for-service program and soft caps on the number available through Medicaid managed care); Sartin-Holloway[43] Dep. 88:24-89:4, Apr. 24, 2018.

3. It Is Reasonable to Expand Community-Based Services Because It Is Cost-Effective.

154. Providing more community-based services would be a cost-effective change for the State of Mississippi if it maximized federal Medicaid dollars, *see infra* § VII.A.3.i, allocated State grants efficiently, *see infra* § VII.A.3.ii, and repurposed spending from State Hospitals to community-based services that reduce the need for State Hospitals, *see infra* § VII.A.3.iii. This is the case because generally the cost of providing community-based services is less than the cost of serving people in State Hospitals. *See infra* § VII.A.3.iv.

i. The State Can Maximize Federal Medicaid Dollars to Fund Community-Based Services that Prevent Hospitalizations.

155. Mississippi does not take common sense steps to maximize its use of available federal Medicaid dollars.

[42] In 2017, actual billing was significantly below these limits. Trial Tr. 1258:21-1259:25, June 14, 2019 (O'Brien).

[43] Kimberly Sartin-Holloway works on special mental health initiatives in DOM's Office of Mental Health. Sartin-Holloway Dep. 6:24-7:20.

156. Generally, services provided to adults aged 21 to 64 in a State Hospital are not eligible for Medicaid reimbursement. 42 U.S.C. § 1396d(a)(B); Windham[44] Dep. 110:24-111:1, May 29, 2018 (State Hospital psychiatric beds are not Medicaid-reimbursable). This is known as the IMD Exclusion. Trial Tr. 1330:22-1331:5, June 17, 2019 (Peet) (The IMD rule "is a federal law that precluded Medicaid reimbursement for institutions of greater than 16 beds serving individuals from 21 to 65 when the mission of the entity was primarily psychiatric care. It was targeted primarily to state hospitals.")

157. In contrast, when someone who is enrolled in Medicaid receives a medically necessary, reimbursable, community-based mental health service and it is billed to Medicaid, the federal government pays a portion of the bill, with the State paying the remaining portion. Trial Stip. at ¶ 263-264; Trial Tr. 1401:16-22, June 17, 2019 (Peet); PX 407 at 34 (Peet Report). In Mississippi, the federal share is approximately 75%. Trial Stip. at ¶ 264.

158. Most people who are admitted to a State Hospital in Mississippi are enrolled, or eligible to be enrolled, in Medicaid. PX 488 at 4 (MSH Utilization Review Committee Minutes, May 11, 2017) (showing, in the period 1/1/16-4/30/17, 80% of males and 85% of females admitted to MSH receiving units had Medicaid or Medicaid plus another form of insurance, indicating that individuals who are likely to be eligible for PACT are also likely to receive or be eligible for Medicaid).

159. Even though many of the services at issue in this case—PACT, mobile crisis services, crisis stabilization services, peer support services, and community support services—are eligible for reimbursement under Medicaid in Mississippi, Trial Stip. ¶ 266, the State leaves

[44] Bonlitha Windham was Director of Mental Health Programs at DOM until May 2017. Windham Dep. 8:19-23, 9:9-11, May 29, 2018.

federal money on the table by not billing Medicaid for all eligible services. *See, e.g.,* PX 407 at 20-21 (Peet Report); PX 420 at 3 (Total Medicaid Mobile Crisis Calls and Contacts v. Crisis Response Medicaid Claim Lines 2017) (providers billed Medicaid for less than half of their mobile crisis contacts with individuals on Medicaid); Trial Tr. 1404:20-1406:5, June 17, 2019 (Peet) (data reveals that Medicaid was billed for "less than half of the [mobile crisis] service that was delivered" to people on Medicaid); *see also* PX 423 at 4 (Medicaid billing for mobile crisis).

160. For instance, in 2017, only 163 of 387 individuals who received PACT had a Medicaid claim for the service, even though it would be expected that nearly all individuals receiving PACT would have a Medicaid claim for the service. PX 422 at 1 (Summary of Individuals Served by PACT Team); PX 407 at 21 (Peet Report); Trial Tr. 1413:18-1414:19, June 17, 2019 (Peet) ("significantly fewer people billed than were served" and "the disparity seems to be growing"); Trial Tr. 2361:3-6, June 27, 2019 (Mikula) (most people on PACT teams are likely eligible for Medicaid); Day Dep. 202:19-203:14, March 22, 2018 ("[M]ost of the individuals in PACT are Medicaid eligible[.]").

161. As another example of the State not maximizing federal Medicaid dollars, supported employment for individuals with mental illness could be added to the list of services available for Medicaid reimbursement in Medicaid, but the State has not added it to the list. PX 407 at 22 (Peet Report); Trial Tr. 1415:7-24, June 17, 2019 (Peet) (State could fund its supported employment service through a Medicaid waiver and indicated an intent to do so, but has not); Trial Tr. 1635:5-12, June 19, 2019 (Hutchins) (DMH explored the possibility of adding supported employment as a Medicaid service through the 1915(i) waiver since at least 2016, but it was not a Medicaid service in Mississippi as of December 31, 2018); Trial Tr. 2361:10-22, June 27, 2019 (Mikula); *see also* JX 18 at 14 (DMH Progress Update on Mississippi's Public

Mental Health System, Sept. 1 2017) (acknowledging DMH was approved for a 1915(i) waiver to provide services to persons with intellectual or developmental disabilities in 2013); 42 U.S.C. §§ 1396n(c), (i).

162. When Medicaid dollars are not used to fund a service, the State generally bears the full cost of the service through appropriations that are in turn distributed through grants to the CMHCs. *See* PX 407 at 33 (Peet Report) (State using grant dollars to pay for PACT services that are Medicaid reimbursable); Trial Tr. 1398:17-1399:20, June 17, 2019 (Peet); Trial Tr. 1584:14-22, June 19, 2019 (Hutchins) (adding PACT as a Medicaid service was "significant" because it provides a payer source); PX 182 (FY 2017 DMH grants for adult mental health services).

163. Money spent on grants for services that can be billed to Medicaid could instead be used to support other services. *See* Mikula Dep. 260:11-19, Mar. 28, 2019 (with increased use of Medicaid funds for mental health services, "there is the potential" to make more DMH funds available to expand community-based services).

164. Though the State loses money when it does not bill Medicaid for these Medicaid eligible services, it does not take basic steps to maximize reimbursement:

a. The State has not imposed a requirement that CMHCs bill all eligible services to Medicaid. Trial Tr. 2360:10-18, June 27, 2019 (Mikula); *see also* Trial Tr. 1404:12-19, June 17, 2019 (Peet) (State can establish a requirement that providers bill Medicaid for eligible services).

b. The State has not provided guidance to CMHCs on how to maximize Medicaid enrollment and reimbursement. *See, e.g.*, Trial Tr. 554:1-12, June 10, 2019 (Sistrunk); Trial Tr. 2324:22-2325:10, June 27, 2019 (Mikula) (agreeing State needs to encourage enrollment in

Medicaid); Day Dep. 12:19-13:1, 150:2-11, Mar. 22, 2018 (DMH does not currently do anything to encourage CSUs to maximize their use of Medicaid dollars).

c. The State does not track billing to identify Medicaid under-billing or under-enrollment. Trial Tr. 2097:17-23, June 25, 2019 (Allen) ("We have to trust the [CMHCs] to maximize their billing opportunities.")[45]; Hutchins Dep. 7:5-9, 45:8-11, 145:11-17, 146:1-21, June 11, 2018; Windham Dep. 81:3-17, May 29, 2018.

ii. The State Could Fund More Community-Based Services by Efficiently Allocating Grant Money.

165. Like Medicaid dollars, the State does not efficiently spend its own grant dollars.

a. State grant dollars could be used for uncompensated care for the relatively few people who are not eligible for benefits after receiving assistance in applying for them. Trial Tr. 1414:12-1415:6, June 17, 2019 (Peet).

b. State grant dollars could be used to develop new services, with the expectation that grants would reduce over time as Medicaid billing increased.[46] Trial Tr. 1414:20-1415:6, June 17, 2019 (Peet); Trial Tr. 2286:3-17, 2287:10-16, June 26, 2019 (Chastain) (MSH director proposed using MSH budget as start-up funds for a CSU in Hinds County in 2012; CSU would only need start-up funds because it could bill Medicaid for operating costs); Breland[47] Dep.

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[45] The State's "trust" that the CMHCs will make financially sound decisions without any oversight by the State appears misplaced in light of the fact that, as of December 31, 2018, at least one CMHC was "having trouble paying [its] bills." Trial Tr. 2368:9-14, June 27, 2019 (Mikula).

[46] Through the testimony of Jake Hutchins, the State advanced the argument that it would cost up to $6,600,000 to fund 11 PACT teams. Trial Tr. 1611:3-8, June 19, 2019 (Hutchins). This argument includes unfounded assumptions and ignores crucial facts. First, the State need not provide grants, in perpetuity, of $600,000 to every PACT team every year. *See* Trial Tr. 1629:22-1630:1, 16:30:16-20, June 19, 2019 (Hutchins) (confirming that one PACT team does not receive $600,000 in grant funding and other PACT teams have not used all of the PACT grant funds). Second, the State's estimate completely ignores federal Medicaid funding. Trial Tr. 1629:17-21, June 19, 2019 (Hutchins).

[47] Kelly Breland is Director of DMH's Bureau of Administration, responsible for the fiscal components of DMH's Central Office. Breland Dep. 7:7-12, 7:20-8:5, Apr. 19, 2018.

90:21-23, 92:19-93:14, Apr. 19, 2018 (CMHC's reliance on DMH grants for CSUs has not decreased since 2012; DMH does not routinely collect data on CSUs' Medicaid billing.); PX 158 (email from MSH director noting that "Medicaid's paying for CSU services will somewhat decrease the CMHC's reliance on the DMH grant"); Day Dep. at 202:13-203:17, March 22, 2018 (DMH allocated PACT grant funding with the expectation that CMHCs would eventually fund them through Medicaid, allowing the State to reallocate grant dollars toward additional PACT teams; as of March 2018, this had not occurred for any of the State's PACT teams).

c. State grant dollars could be allocated based on need rather than on past allocations, which is the current way the State awards grant dollars. *See* Trial Tr. 2366:16-2367:1, June 27, 2019 (Mikula); Allen Dep. 119:4-16, June 14, 2018 (all 16-bed CSUs get an annual DMH grant of $1.45 million, regardless of how much federal Medicaid funding they receive); Mikula Dep. 183:24-184:7, Mar. 28, 2019 (Through March 2019, "the process for certain [DMH] funds to be allocated has been heav[il]y, if not fully, dependent on how things have worked in the past."). This results in some CMHCs receiving more than they need. Trial Tr.1630:16-20, June 19, 2019 (Hutchins) (There have been occasions when a CMHC did not use all of the $600,000 in DMH grant funding provided for its PACT program.); *see also* Trial Tr. 2367:2-15, June 27, 2019 (Mikula) (PACT teams receive $600,000 grants regardless of need).

166. Moreover, in at least one program—CHOICE— the State is not even spending all available state dollars, meaning it could serve more people without increasing the budget. PX 12 (CHOICE has never spent the full amount appropriated by the legislature); Trial Tr. 692:6-693:12; 694:16-22, June 10, 2019 (Parker) (MUTEH could serve between 200 and 240 people per year in the CHOICE program with current funding).

iii. The State Could Repurpose Funds from State Hospitals to Community-Based Services that Reduce the Need for State Hospitals.

167. In addition to efficiently spending existing dollars dedicated to community-based services, the State can repurpose how it spends its money to fund additional community-based services. Trial Tr. 805:22-806:21, June 11, 2019 (Bell-Shambley) (Alabama downsized hospitals and expanded community services in order to assure Alabama was "getting the best results that [it] could for the consumers [it] served with the dollars [it] had"); Trial Tr. 1190:1-1190:16, June 13, 2019 (Ladner) (describing MPA's 2010 recommendation to reallocate funds from the Central Mississippi Residential Center to community-based services); Allen Dep 17:25-18:10, 37:25-38:8, June 14, 2018 (shifting funds is "the only way right now").

168. The State has long recognized that shifting from an institution-based to a community-based system of care requires shifting resources from the State Hospitals to the community and increasing the availability and use of community-based services, mirroring a national shift in spending. PX 363 at 1 (PEER Report # 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis, June 26, 2008); PX 43 at 5 (2009 Strategic Plan goals and objectives); Trial Tr. 2345:18-2346:11, June 27, 2019 (Mikula) (in 2009 DMH set a goal of developing a 5-year plan to redistribute funding; no such plan was ever created).

169. In 2009 DMH was in fact instructed to develop a long-term plan to reallocate resources by a committee of the Mississippi legislature—the same legislature that funds DMH with annual appropriations. PX 363 at 1, 10, 63 (PEER Report # 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis, June 26, 2008).

170. Nonetheless, DMH only began shifting funds from the State Hospitals to the community in 2018. JX 47 at 3-5 (DMH Executive Staff Meeting presentation Apr. 18, 2018) (describing services to be funded by $8 million funding shift); Allen Dep. 26:14-27:3, 57:11-13,

June 14, 2018 ("[T]his is the first shift, true shift."); Mikula Dep. 143:18-23, Mar. 28, 2019 (shift in funds of $8 million occurred in FY 2019).

171. Despite having, for a decade, the goal of shifting funds from State Hospitals to community-based services, the State still disproportionately allocates its mental health spending to State Hospitals. As of 2018, DMH spent over $100 million a year in State funds for the State Hospitals and $27 million a year in State grants to fund community services. JX 52 at 31 (DMH FY18 Annual Report).

172. Compared to other states, Mississippi allocates significantly more of its budget (including federal dollars) to institutional settings and less to community-based services. PX 407 at 29 (Peet Report) (national average is 75% on community-based services while Mississippi spending is 61% on community-based services); *see also* Trial Tr. 1544:3-19, June 19, 2019 (Lutterman) (Mississippi's proportion of spending on community-based services in 2015 was less than the national rate of spending on community-based services in 2006).

173. Excluding Federal Medicaid dollars, the State calculated that only 35.65% of its mental health spending went to community-based services in FY 2017. PX 319 (DMH calculation of funding allocation); PX 407 at 29 (Peet Report); Trial Tr. 1418:25-1419:22, June 17, 2019 (Peet).[48]

174. Unrealized cost savings exist within the State Hospitals, even at current capacity.[49] *See* Trial Tr. 2289:25-2292:4, June 26, 2019 (Chastain) (describing 300+ acre MSH campus, including more than 100 buildings, close to half of which are no longer operational, a

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[48] Notably, the State does not track this breakdown on a regular basis. Allen Dep. 69:5-15, June 14, 2018.

[49] The failure to provide community-based mental health services comes with additional hidden costs. *See, e.g.*, Maddux Dep. 179:1-14, May 7, 2018 (agreeing that increasing mental health services "not only eliminates … social costs, it also results in additional sources of revenue for state systems.").

maintained former golf course, and a fleet of 75 vehicles); Mikula Dep. 241:1-19, Mar. 28, 2019 (DMH has not assessed whether it could generate funds by selling land currently occupied by a DMH facility or by leasing vacant MSH buildings to a tenant).

175. For example, the 2018 shift in $8 million from MSH was accomplished by a one-time spending of unencumbered cash on hand. JX 21 at 1 (MSH FY19 Budget Request); Trial Tr. 2269:3-11, 2271:13-21, June 26, 2019 (Chastain); Matson[50] Dep. 43:21-44:2, June 27, 2018. MSH had built up this store of unencumbered cash even as its budget had been cut for several years prior. *Compare* JX 21 at 1 (MSH FY19 Budget Request) (showing growth in unencumbered cash from FY 2017 to FY 2019) *with* Trial Tr. 2035:18-25, June 25, 2019 (Allen) (describing years of budget cuts).

iv. State Hospital Care is Generally More Expensive than the Community-Based Services that Reduce the Need for State Hospital Care.

176. Shifting resources from State Hospitals will enable the State to serve more people in community-based settings in part because it is generally less expensive to serve people in community-based settings than in State Hospitals.

a. Using the State's Medicaid billing data, Kevin O'Brien—an expert in health systems cost analysis, Trial Tr. 1246:14-19, June 14, 2019 (O'Brien)—estimated the cost of providing key community-based services that were recommended by the Clinical Review Team for many individuals in the sample. *See, e.g.,* PX 404 at 11-15 (Drake Report) (identifying key community-based services); PX 407 at 10 (Peet Report) (identifying key community-based services); PX 409 at 10-11 (O'Brien Revised Report).

[50] Amanda Matson is MSH's Director of Revenue, responsible for preparing the annual budget. Matson Dep. 6:19-7:6, June 27, 2018.

b. The average annual per person cost of treatment in a State Hospital is more than the cost of providing community-based services, especially when the individual is enrolled in Medicaid. PX 409 at 10-16 (O'Brien Revised Report); PX 410 at 6-11 (O'Brien Supplemental Report); *see also* PX 1078 at 405 ("[R]igorous economic analyses have found that ACT is cost-effective when programs adhere closely to the model in serving high-risk consumers. Cost studies have found that reduced hospitalization costs offset the costs of ACT . . . .").

c. That conclusion holds even when considering 1) the cost of additional services beyond the services initially included in Mr. O'Brien's analysis, and 2) the likelihood that a person would receive those services. PX 410 at 12-15 (O'Brien Supplemental Report); Trial Tr. 1274:18-1275:10, June 14, 2019 (O'Brien).

d. Although a shift in resources might require initial upfront spending, Mr. O'Brien's analysis is reliable and demonstrates that on average the State would spend less by serving individuals with community-based services, rather than in State Hospitals.[51]

e. Even the State's experts admit that the cost of serving people in community-based settings and the cost of serving people in State Hospitals is comparable. DX 301 at 4 (Fowdur Report) (the average costs of each modality of care are comparable);[52] Trial Tr. 2432:21-24, June

[51] Given the many variables at play, most of which are in the State's control and discretion—i.e. whether and to what extent to rely on federal Medicaid funding, and the particular service models and requirements the State chooses to impose—an estimate is the best available information. PX 407 at 32-34 (Peet Report); Trial Tr. 1416:9-1417:15, 1459:6-1460-12, June 17, 2019 (Peet) (State policy choices could reduce or increase cost of community service expansion; there is no standard formula for service capacity or cost). No precise formula exists to pinpoint the exact cost. PX 396 at 13 (The Role of Inpatient Bed Capacity in Determining Psychiatric Inpatient Bed Capacity) ("Nor is there a standard formula to apply when seeking to project or estimate the number of inpatient beds that should exist in a system.").

[52] The State did not submit a cost analysis but instead submitted a report from Dr. Lona Fowdur that purported to adjust for alleged flaws in Mr. O'Brien's methodology. Trial Tr. 1789:1-4, June 20, 2019 (Fowdur).

Dr. Fowdur's critiques of Mr. O'Brien's methodology are not entitled to significant weight. Dr. Fowdur made two adjustments to Mr. O'Brien's estimate of annual hospital costs, both of which are fundamentally flawed. First, Dr. Fowdur removed fixed costs from the estimate of the annual hospital costs. *Id.* at 1735:6-18. However, Dr.

27, 2019 (Geller) (the best available data indicate that hospital and community-based services cost about the same).

f. If the State expanded community-based services, demand for State Hospital services (both the number and length of admissions) would decrease. PX 367 at 61 (PEER Legis. Report #58 - A Review of the Closure of the Mississippi State Hospital's Community Services Division, June 10, 2014) ("PEER notes that some of this demand for inpatient care could be due to the scarcity of community-based options."); PX 888 at 2 (Nov. 14, 2017 email from Marc Lewis re FW: Adult Psychiatric Commitments/Crisis Stabilization Units) (describing policy to refer every State Hospital commitment to CSUs for possible diversion, which would "reduc[e] the reliance on inpatient beds at our hospitals"); Trial Tr. 1365:1-9, 1366:16-1367:11, June 17, 2019 (Peet) (demand for hospital beds decreases as community services expand). This, in turn, would allow the State Hospitals to downsize and reduce the fixed costs associated with the State Hospitals. Trial Tr. 1284:20-25, June 14, 2019 (O'Brien) (over extended periods of time, fixed costs become variable costs); Trial Tr. 1755:23-1756:15, June 20, 2019 (Fowdur)

Fowdur's fixed cost assumptions were contradicted by contemporaneous budget documents. *Compare* DX 301 at 15 (Dr. Fowdur's fixed cost adjustments relies on deposition testimony that the cost of reopening beds at SMSH was $190,000) *with* PX 978 at 50 (FY18 SMSH Budget Request) (cost of reopening beds is $301,361). Second, Dr. Fowdur removed all costs – fixed and variable – associated with individuals who spent more than 60 days in a calendar year in a State Hospital. Trial Tr. 1735:6-18, June 20, 2019 (Fowdur). This adjustment assumed that those individuals can never be discharged, *id.* at 1735:12-18, an assumption flatly contradicted by the State. DX 12 at 1 (Updates to Community-Based Services) (describing transition of individuals from MSH's continued treatment unit).

As to Mr. O'Brien's community-based cost estimates, Dr. Fowdur's primary critique is that Mr. O'Brien is under-inclusive. Dr. Fowdur's correction suffers from the opposite problem: it is over-inclusive. Her calculation fails to account for the frequency with which individuals receive any given community-based service. *See, e.g.*, PX 410 at 14 (O'Brien Supplemental Report) (noting Dr. Fowdur's assumption that all individuals would receive electroconvulsive therapy, at a cost of $3,598.73 per person, even though only .03% of individuals in the Magnolia data set received that service). Mr. O'Brien's supplemental report, PX 410, addresses his alleged under-inclusion and arrives at the same conclusion as his initial report: community-based services are generally less expensive than State Hospital treatment. PX 410 at 15; Trial Tr. 1274:8-1275:10, June 14, 2019 (O'Brien).

Most notably, despite her flawed analysis, Dr. Fowdur's ultimate conclusion is that the costs are comparable. DX 301 at 4 (Fowdur Report).

(with reduction in the hospital population, over time units and buildings at Mississippi State Hospital could close, turning fixed costs into variable costs).

177. The State has not evaluated whether it could save money by increasing community-based services and decreasing the use of State Hospitals. PX 367 at 61 (PEER Legis. Report #58 - A Review of the Closure of the Mississippi State Hospital's Community Services Division, June 10, 2014) ("DMH has not developed any estimates of cost savings that might be derived from moving institutional residents to community-based services."); Trial Tr. 1641:14-1642:9, June 19, 2019 (Hutchins) (no cost estimates completed for the expansion of community-based services included in the FY 2018-2020 DMH Strategic Plan or earlier versions); Mikula Dep. 157:11-20, Mar. 28, 2019.

178. The State has not shown that implementing the requested relief would compel reduction of services, or otherwise be inequitable, to other individuals with disabilities.

4. There Is a Clear Process For Expanding Statewide Provision of Community-Based Services to Prevent Hospitalization.

179. Ensuring statewide availability of services for those who need them to avoid unnecessary institutionalization is an achievable target, as explained by Melodie Peet. Trial Tr. 1380:10-1382:22, June 17, 2019 (Peet).

180. The first step in this expansion is establishment of a baseline of the key services in each CMHC region of the State. Trial Tr. 1450:15-25, June 17, 2019 (Peet) ("[O]nce you establish the core services for your service systems, you want to make sure they're available in each region so that access isn't dependent on where you live."); *see also* PX 407 at 23-24 (Peet Report).

181. The initial baseline service capacity would include one PACT team in each CMHC region; one crisis stabilization unit in each CMHC region; mobile crisis capacity capable

of responding to a crisis within the time required by DMH standards; supported housing capacity as estimated by the State; a supported employment presence at each CMHC region; intensive case management[53] provided with sufficient intensity to prevent hospitalizations in each CMHC region; and peer support in sufficient quantities to weave into existing services. Trial Tr. 1384:22-1385:16, 1389:11-1392:9, June 17, 2019 (Peet); *see also* PX 407 at 19-24 (Peet Report).

182. After the baseline is established, the State would expand service capacity on a regional level beyond the baseline based on State Hospital and community service utilization data showing where and how much additional services are needed. Trial Tr. 1381:3-1382:7, 1392:16-1393:21, 1396:12-1397:14, 1413:5-17, June 17, 2019 (Peet); *see also* PX 407 at 23-24 (Peet Report).

183. Among other indicators, data on commitments by CMHC region, repeat admissions to State Hospitals, long stays in State Hospitals, and use of CSUs are relevant data points to track when identifying need for services. Trial Tr. 1392:16-1393:21, 1396:18-23, 1397:11-14, June 17, 2019 (Peet).

184. The State does not currently review or analyze data to determine service capacity and needs. *See, e.g.*, PX 407 at 31 (Peet Report); Trial Tr. 1639:4-1640:10, June 19, 2019 (Hutchins) (Central Data Repository ("CDR") data not used to drive programmatic changes); Trial Tr. 1396:12-17, June 17, 2019 (Peet) (executives are not using data in a regular way); Allen Dep. 10:24-11:8 June 14, 2018 (only data he reviews on a regular basis is State Hospital bed availability); Holloway Dep. 34:12-35:5, 104:14-107:19, May 23, 2018; Hurley Dep. 48:25-49:14, Apr. 26, 2018 (data reported for grants is used only for grant reimbursement purposes);

[53] In Mississippi, intensive case management is within the service definition of Community Support Services. Trial Tr. 1344:11-15, June 17, 2019 (Peet).

Toten Dep. 21:22-22:18, 109:8-16, 133:13-134:11, 140:15-17, 194:16-19, 208:25-209:4, May 23, 2018 (Division of Medicaid does not assess utilization of services geographically or against service caps to determine sufficiency of, or need for, services); *compare* Trial Tr. 1640:16-24, June 19, 2019 (Hutchins) (no receipt of quarterly data from Division of Medicaid regarding funding or utilization of services) *with* Sartin-Holloway Dep. 169:20-171:14, Apr. 24, 2018 (DOM provides DMH with quarterly and annual reports of service use and cost).

185. Expansion of these services requires intensive education and technical assistance for providers. Trial Tr. 1354:2-7, June 17, 2019 (Peet) (State oversight and technical assistance is necessary particularly for providers who have not previously run these services). Such technical assistance should be ongoing and may involve bringing in external experts to consult or establishing regular opportunities for providers to learn from one another. PX 407 at 31 (Peet Report); Trial Tr. 1356:1-10, 1383:21-1384:21, 1398:11-16, June 17, 2019 (Peet) ("[O]versight is not at all too strong a word. In fact it's a key responsibility…."); *see also* JX 4 at 4 (MAC Plan Update, May 12, 2016 Draft) ("Ongoing training of public and private providers, advocacy groups, as well as state agency employees, is critical to compliance with the MAC goals."); JX 30 at 16 (DMH Community Mental Health Services FY16-FY17 State Plan) (a "major responsibilit[y]" of the state is "to plan and develop community mental health services"); Trial Tr. 371:21-372:6, June 6, 2019 (VanderZwaag) (describing mandatory training, provided by UNC Center for Excellence, for all ACT teams in North Carolina).

186. The State is not currently providing this education and technical assistance to ensure the services are provided in accordance with its own standards and expectations. Trial Tr. 105:6-15, June 4, 2019 (Drake) (Mississippi's services on paper are appropriate, but are not provided as described in regulations to those who need them); Trial Tr. 348:1-20, June 5, 2019

(Worsham) (DMH is "not doing the very thing that actually would make a difference. It's like they stop right at that point to do the very thing that actually would make a difference. . . . So there is a lot of talk, there is a lot of planning, but there is also a lot of people being hurt in the process . . . . And it's frustrating because they are not enforcing their own policies on the provider level."); Trial Tr. 431:9-432:9, June 6, 2019 (VanderZwaag) (although DMH's Operational Standards require services to be person-centered, people she reviewed did not receive person-centered services); *see also* Trial Tr. 554:1-12, June 10, 2019 (Sistrunk) (no guidance on increasing enrollment or Medicaid reimbursement); Trial Tr. 2097:17-23, June 25, 2019 (Allen) ("I don't work at a community mental health center" as justification for not assessing Medicaid billing practices); Trial Tr. 2209:6-15, June 26, 2019 (Crockett) (changes to discharge planning process in one region were result of that region's director's "personal initiative").

187. An assertive approach is sometimes necessary to engage adults with SMI in treatment, but the State does not educate or set expectations with providers regarding the need to take such an approach. *See* PX 406 at 7 (Burson Report); Trial Tr. 395:14-17, June 6, 2019 (VanderZwaag); Trial Tr. 603:2-605:3, June 10, 2019 (Byrne); Trial Tr. 1097:18-1098:25, June 12, 2019 (Burson).

B. It is a Reasonable Modification to Identify, Screen, and Assess Individuals to Determine Their Appropriateness for Community-Based Services and Connect Them to Those Services.

188. The State is aware of individuals who are in need of community-based mental health services to avoid hospitalization. It is reasonable to require the State to use that knowledge to connect those individuals to services.

a. For example, the State could, but does not, refer to PACT anyone who enters a State Hospital and already has a previous hospital admission. *See* JX 15 at 119, 121 (2019 DMH Budget Request: Program Performance Indicators and Measures); JX 60 at 217 (DMH Operational Standards) ("[h]igh use of acute psychiatric hospitals" is the first criterion listed for receiving PACT in Mississippi); PX 422 at 2 (Summary of Individuals Served by PACT Team); Trial Tr. 1398:17-1401:6, June 17, 2019 (Peet) (State has unused PACT capacity, but number of people State Hospitals refer to PACT is "surprisingly low").

b. The State could, but does not, refer to CHOICE anyone who enters a State Hospital and may be in need of CHOICE services. Trial Tr. 693:5-18, 699:5-700:25, 705:10-13, June 10, 2019 (Parker); *see also* Trial Tr. 2324:4-21, 2362:6-8, June 27, 2019 (Mikula) (DMH's only step to increase referrals to CHOICE was to arrange meetings with CMHCs and State Hospital staff to increase knowledge of the program; there is no policy requiring referral.).

c. The State could, but does not, use State Hospital data to identify people with particularly long stays or repeated admissions and connect them with services they need to avoid future admissions. PX 419 (map of home addresses of the 30% of patients who account for 73% of total State Hospital bed days, October 2015 to October 2017); PX 421 at 2 (chart showing approximately 1,200 individuals accounted for 72.5% of State Hospital bed days between October 2015 and October 2017); Trial Tr. 1337:10-1338:7, 1381:6-1382:7, 1389:5-10, June 17, 2019 (Peet) (State data indicates that a relatively small number of people is using a significant majority of State Hospital capacity, and those individuals should be targeted early for identification and connection to services.); Reeves Dep. 24:11-25:15, May 8, 2018 (committee that monitors readmission rates stopped meeting regularly).

d. The State could, but does not, maintain its data in a way that enables State Hospitals or community providers to identify service utilization history of individuals who are in or at risk of entering State Hospitals. Trial Tr. 2368:1-8, June 27, 2019 (Mikula) (DMH central office lacks the ability to review whether individuals received community-based services before being committed.); Jones[54] Dep. 15:8-19, 35:21-36:3, 42:9-18, June 27, 2018 (State Hospitals are not able to use the information from DMH's Central Data Repository to determine whether a person has received services from a CMHC before being admitted to the State Hospital, and they have no way to access the person's CMHC electronic health record.); *see also* Vaughn Dep. 30:20-32:7, 32:17-34:6, 35:11-21, Mar. 29, 2018 (upon admission to crisis stabilization unit, no review to see if person had been receiving community-based services).

189. The State has recognized the need to make use of data to drive service development. JX 4 at 2 (MAC Plan Update, May 12, 2016 Draft) (recognizing need to assess capacity of existing community services and the number of people currently in institutional settings who desire and would benefit from community services); PX 119 at 24 (DMH FY 2016-2017 State Plan).

C. It Is a Reasonable Modification to Engage in Effective Discharge Planning.

190. Because the State recognizes that effective discharge planning can prevent State Hospital admissions, it is reasonable to require the State to provide effective discharge planning. *See, e.g.*, Trial Tr. 1957:14-17, June 24, 2019 (Reeves) (Discharge planning is a major factor in how patients discharged from the hospital will do.); Maddux Dep. 54:9-55:10, May 7, 2018 (A State Hospital readmission "could very well mean" that there was not "successful reintegration back into the community," which is "[t]he goal of discharge planning."); Newbaker Dep. 51:23-

[54] Denise Jones is DMH's Chief Information Officer. Jones Dep. 7:6-13, June 27, 2018.

52:19, Apr. 12, 2018 (State Hospitals have a responsibility, through discharge planning, to not set individuals up for "failure" in the community, including by avoiding placing them "where they won't have availability of services.").

191. It is reasonable to require the State to comply with its own policies and asserted practices related to discharge planning. Mikula Dep. 49:22-52:11, 56:2-21, Mar. 28, 2019 (transition work group first met in February 2019); Reeves Dep. 48:3-13, May 8, 2018 (Discharge planning should start "fairly soon after the patient is admitted."); *see supra* § IV.B.

192. The fact that MSH engages in discharge planning for Region 9 clients that is similar to the model of effective discharge planning sought in this case indicates that implementing that model statewide is reasonable. Trial Tr. 2203:7-2204:4, 2209:3-24, June 26, 2019 (Crockett).

D. The State's Arguments That These Modifications Are Not Reasonable Because of Federal Law and Policies Is Wrong.

193. There are federal laws, policies, regulations, and funding decisions that impact mental health care in Mississippi, as in every state of the United States of America.

194. These policies do not prevent the State from providing community-based services or from reducing unnecessary hospitalizations. PX 407 at 8-9 (Peet Report); Trial Tr. 1472:20-24, June 17, 2019 (Peet).

195. Other states, working under the same federal laws, policies, regulations, and funding decisions as Mississippi, are able to provide community-based services that prevent unnecessary hospitalization. PX 407 at 4 (Peet Report); Trial Tr. 254:18-255:2, 261:5-262:4, June 5, 2019 (Drake) (Many states, including South Carolina, have done "very well" in expanding supported employment statewide, including by using Medicaid waivers to fund "large

aspects" of the service.); Trial Tr. 1331:12-17, June 17, 2019 (Peet) (IMD exclusion did not prevent Connecticut or Maine from shifting toward community-based care.).

196. Further, the federal government recently afforded states the opportunity to seek waivers of the exclusion for Medicaid funding for Institutes of Mental Disease (IMDs). JX 54 at 12 (Letter from CMS to State Medicaid Directors, Nov. 13, 2018); Trial Tr. 1330:22-1331:11, June 17, 2019 (Peet) (federal government announced opportunity in 2018).

VIII. The State Cannot Establish Its Fundamental Alteration Affirmative Defense.

197. The State cannot establish a fundamental alteration affirmative defense because it has not proven that it has an effectively working *Olmstead* plan and because it has not proven that implementing the modifications sought would be so cost prohibitive as to be a fundamental alteration.[55] *See supra* § VII.A.3.

A. The State Cannot Identify Its *Olmstead* Plan.

198. The Department's Deputy Executive Director has "never seen" a Mississippi *Olmstead* Plan, and he claims such a plan would be "useless" for the State. Trial Tr. 2025:7-25, June 25, 2019 (Allen); Allen Dep. 164:23-24, June 14, 2018.

199. In contrast, the Department's Executive Director testified that the State's *Olmstead* plan is a collection of documents including annual strategic plans, strategic plans submitted in connection with annual budget requests, and the 2001 Mississippi Access to Care ("MAC") Plan, along with its 2003 and 2016 updates.[56] Trial Tr. 2316:9-2317:2, June 27, 2019

[55] The State asserted a fundamental alteration argument on the basis of cost about a single proposed modification: expansion of community-based services. *See* Miss. Trial Bench Br. 15-17, ECF No. 208; Trial Tr. 1610:16-1611:8, June 19, 2019 (Hutchins). As discussed above, that argument is wrong.

[56] Although she testified that the MAC plans are part of the State's *Olmstead* plan, Ms. Mikula has no involvement in those plans. Trial Tr. 2317:3-5, June 27, 2019 (Mikula).

(Mikula); *see also* JX 4 (MAC Plan Update, May 12, 2016 Draft); JX 16 (MAC Implementation Report, May 30, 2003); JX 17 (MAC Report, Sept. 30, 2001); Bailey[57] Dep. 34:22-35:8, 41:14-42:22, May 9, 2018.

200. Testimony that the strategic plans are how DMH holds itself accountable, *e.g.* Trial Tr. 2026:1-8, 2079:18-19, 2109:4-20, June 25, 2019 (Allen), is inconsistent with testimony that the strategic plans are "living breathing document[s]" that "change[] all the time." *Id.*

201. The State's inconsistency on the issue of whether there is an *Olmstead* Plan indicates that there is no comprehensive *Olmstead* Plan, let alone one that is effectively working to address the unnecessary institutionalization.

B. The Documents Purportedly Forming the State's *Olmstead* Plan Are Insufficient.

202. Even assuming that the DMH strategic plans are the State's *Olmstead* Plan, they are not comprehensive or effectively working. *See infra* Conclusions of Law ¶¶ 37-42.

203. The documents are not comprehensive because they are not operational plans that provide guidance on how to ensure access to needed services. PX 407 at 25-26 (Peet Report); Trial Tr. 1379:17-1380:5, June 17, 2019 (Peet).

204. The documents are not comprehensive because, even if every goal were met, that would not result in statewide availability of the key services that prevent hospitalization, provided in accordance with DMH's Operational Standards. *See, e.g.*, Trial Tr. 2060:24-2062:10, June 25, 2019 (Allen) (The strategic plan does not require a PACT team in every region.); JX 65 at 23 (DMH Strategic Plan FY 2013-2017); Trial Tr. 2062:21-2063:24, June 25, 2019 (Allen) (DMH did not meet FY 2013-2017 strategic plan goal of establishing 15

[57] At the time of her deposition, Wendy Bailey was Director of DMH's Bureau of Outreach, Planning & Development. Bailey Dep. 5:10-13, May 9, 2018. Her job responsibilities included strategic planning. *Id.* at 8:8-16.

community support teams across the state by 2013; the current strategic plan lacks any goal for this service.); JX 53 at 13 (DMH FY 2019-FY 2021 Strategic Plan); Trial Tr. 2064:1-2065:12, June 25, 2019 (Allen) (Current strategic plan's supported employment goal, to employ an additional 75 individuals statewide, does not call for providing service in every CMHC region.); JX 50 at 9 (DMH Strategic Plan FY18 End-of-Year Progress Report, Sept. 2018); Trial Tr. 2066:22-2071:22, June 25, 2019 (Allen) (Strategic plan does not track whether mobile crisis teams actually respond to calls in each county.).

205. The documents are not comprehensive because they lack certain key goals that would reduce and prevent unnecessary institutionalization. *See* JX 53 (DMH FY 2019-FY 2021 Strategic Plan) (no goals related to connecting individuals with multiple State Hospital admissions to PACT and/or CHOICE; no goals related to increasing CMHC involvement in discharge planning).

206. The documents are not comprehensive because, in most cases, even the goals that *are* in the plans are not measurable. JX 50 at 10 (DMH Strategic Plan FY18 End-of-Year Progress Report, Sept. 2018) (housing goal is "on track" with 6 additional people housed through CHOICE from FY 2017 to FY 2018); Trial Tr. 2075:11-2076:15, June 25, 2019 (Allen) (supported housing goal is to increase the number of people with SMI served, without any specific target); JX 53 at 13 (DMH FY 2019-FY 2021 Strategic Plan) (identifying goal of "[d]ivert[ing] individuals from more restrictive environments such as jail and hospitalizations by utilizing [CSUs]," without any specific target); PX 407 at 25-26 (Peet Report); Trial Tr. 2288:17-22, June 26, 2019 (Chastain) (MSH's strategic plans never identify target numbers for goals and outcomes.).

207. In the unusual case where the goal is measurable, there is no discernible rationale for the chosen goal.

a. For instance, the goal to increase the use of PACT teams by 25%, JX 53 at 13 (DMH FY 2019-FY 2021 Strategic Plan), was set without an assessment of the need for PACT across the State, Trial Tr. 2341:1-22, 2343:15-21, June 27, 2019 (Mikula) ("I did not know what the need for PACT services were in any given region."); and without an assessment of why 25% was the appropriate target. Mikula Dep. 97:8-98:1, 118:17-119:7, 130:20-132:3, Mar. 28, 2019; *see also* Mikula Dep. 98:2-15, Mar. 28, 2019 (DMH has not set a target number of State Hospital readmissions for people already served by a PACT team.).

b. As another example, the State set a goal of increasing supported employment by 75 individuals, JX 11 at 4 (DMH Strategic Plan FY 15-FY17 End-of-Year Progress Report, July 16, 2015); JX 53 at 13 (DMH FY 2019-FY 2021 Strategic Plan), with no discernible reason for selecting 75 people as the target. *See* Hutchins Dep. 140:19-22, June 11, 2018; Mikula Dep. 128:20-23, Mar. 28, 2019 (no needs assessment done for supported employment).

208. It is no surprise that the State's Strategic Plan does not identify a rationale for the few selected targets, because the State does not track or use data it could be using to select and justify targets. PX 363 at 79 (PEER Report, June 26, 2008) (summarizing 2001 MAC Plan recommendations, including the need for a comprehensive data collection system; absent that, "it is difficult to ensure that all people with disabilities will have the opportunity to transition into the most integrated environment"); Carlisle Dep. 141:12-142:22, June 15, 2018 (data like EMSH's average length of stay means "absolutely nothing" to EMSH's director); Day Dep. 205:7-18, 251:17-19, Mar. 22, 2018; Mikula Dep. 121:21-122:3, 127:18-21, 128:20-23, Mar. 28, 2019 (DMH Executive Director lacks data to determine if there is unmet need for mobile crisis

and has not reviewed a needs assessment for peer support or supported employment services for individuals with SMI.); *see also supra* ¶ 184.

a. DMH's Deputy Executive Director testified that he "usually [doesn't] get down in the weeds," and he leaves tracking the strategic plans' outcomes, strategies, and outputs to "the people administering the grants and working directly with" the CMHCs. Trial Tr. 2058:22-2060:4, June 25, 2019 (Allen).

b. Those very people, however, did not review or use data related to strategic planning and service utilization. *See, e.g.*, Day Dep. 80:25-81:5, 84:17-21, 117:14-118:15, 119:6-19, 166:16-18, 177:11-178:25, 179:1-5, 184:19-22, 255:18-256:16, 261:9-16, Mar. 22, 2018 *and* Vaughn Dep. 11:22-12:4, 35:11-21, 57:5-14, 66:18-67:3, 97:11-19, 105:12-16, Mar. 29, 2018 *and* Hurley Dep. 39:8-40:3, 41:6-15, 98:10-99:6, 112:24-113:1, Apr. 26, 2018 *and* Holloway Dep. 44:13-45:3, 120:21-122:20, May 23, 2018 (DMH employees responsible for adult community services grants were unaware of collection or review of relevant data.).

209. The DMH strategic plans are not effectively working because they have not resulted in a meaningful decrease in institutionalization in the last five years. PX 412A (Average Staffed Bed Capacity in State Hospitals [corrected]).

210. The strategic plans are not effectively working because until trial in this matter approached they did not include a goal of reducing State Hospital admissions. JX 53 at 11 (DMH FY 2019-FY 2021 Strategic Plan); Carlisle Dep. 70:3-6, 84:17-85:17, 86:10-88:11, June 15, 2018 (EMSH does not plan bed reductions and is constructing new receiving units that exceed current capacity by twenty percent.); Chastain Dep. 36:12-22, 54:11-20, 66:15-67:4, June 13, 2018 (Mississippi State Hospital director acknowledged that "we intend to continue to serve or operate the same number of beds and we need to retain the same number of staff," MSH

budget does not anticipate any changes in MSH programming or efforts to reduce length of stay, and MSH has no targets to reduce lengths of stay.).

211. The strategic plans are not effectively working, because in the last decade, the State has failed to meet a number of goals it set for itself and responded to those failures by moving the goal posts.

a. For instance, the State set goals in the FY 2012 Strategic Plan for statewide coverage of CSUs and intensive case management teams. PX 980 at 20, 22 (DMH Strategic Plan FY 2012-2016). Those goals were not met and were subsequently dropped. JX 53 (DMH FY 2019-FY 2021 Strategic Plan) (no such goals); Mikula Dep. 105:15-107:4, 109:17-110:20, 111:7-17, Mar. 28, 2019.

b. The State set itself a goal of reducing readmissions to the State Hospital by 2%. JX 68 at 11 (DMH FY 16-FY 18 Strategic Plan). That goal was not met. JX 70 at 2 (DMH FY 2016-2018 Strategic Plan End-of-Year Progress Report, Aug. 2016) (average readmissions increased by 0.83%). The next year, the goal changed. JX 69 at 11 (FY 17-FY 19 DMH Strategic Plan).

C. Minimal Changes the State Has Made Over the Last Decade Do Not Constitute A Comprehensive, Effectively Working Plan.

1. *The State Has Long Been on Notice of Its Title II Violation.*

212. The State has had more than a decade of notice that it must modify its mental health system in order to comply with Title II of the ADA.

a. In 2008, the Mississippi Legislature's own PEER Committee warned DMH that it needed to shift its focus. PX 363 at 1 (PEER Report, June 26, 2008) ("Due to implications of the U.S. Supreme Court's 1999 *Olmstead* decision, which supports the drive toward integrating

people with disabilities into the least restrictive settings, the state will be forced to move toward providing more community-based care in the near future.”).

b. In 2010, the Mississippi Psychiatric Association (“MPA”) called on the State to reallocate resources to the community and ensure that effective community-based services are provided to people being discharged from State Hospitals. PX 366 at 37 (MPA Report, 2010) (“[D]eveloping community services depends upon the reallocation of resources that are now in the Department of Mental Health’s institutional budget.”); Trial Tr. 1177:13-1178:4, 1187:21-1188:10, 1189:16-22, 1191:23-1192:9, June 13, 2019 (Ladner).

c. In 2011, the Department of Justice issued its Finding Letter alleging that the State was violating the rights of people with serious mental illness by failing to provide services in the most integrated settings appropriate under the ADA. *See generally* ECF No. 19-1.[58]

d. In 2012, the Strategic Planning and Best Practices Committee recommended that PACT and supported employment, among other services, be required in every CMHC region. PX 861 at 22 (Strategic Planning and Best Practices Committee Report to the Legislature, June 30, 2013).

e. In 2015, the Technical Assistance Collaborative provided the State with its draft report on adult mental health services assessing the then-existing programs for individuals with serious mental illness in the State and making recommendations for how those programs should

[58] The Court may take judicial notice of the fact, contained in filings in this case, that the Department of Justice’s Findings Letter alleged ADA violations in 2011, as reflected in the Court’s publicly available docket. *Special Risk Servs. Grp. v. Trumble Steel Erectors, Inc.*, No. 5:04-CV-289-C, 2006 WL 6632286, at *11 n.6 (N.D. Tex. Feb. 28, 2006); *see also McCoy v. Hous. Auth. of New Orleans*, No. 15-398, 2016 WL 9413929, at *3 & n.35 (E.D. La. Oct. 10, 2016); *In re Smith*, No. 04-50723, 2012 WL 1123049, at *1-2 (W.D. Tex. Apr. 3, 2012) (the court may “take judicial notice of the fact that certain allegations were made” in court filings).

be modified in order to make services available and accessible to those who need them. PX 46 at 1, 7 (TAC Report).

213. The State did not implement many of the recommendations included in the reports described above. *See, e.g.*, JX 60 at 21 (DMH Operational Standards) (PACT and supported employment are not core services.); PX 46 at 24 (TAC Report); PX 413 (Mississippi Counties with Program of Assertive Community Treatment Teams as of 6-30-2018) (PACT not available in every CMHC region); Trial Tr. 2360:10-18, June 27, 2019 (Mikula) (no requirement that PACT teams bill Medicaid for all eligible services, a recommendation from TAC); Maddux Dep. 73:23-74:3, 76:4-19, May 7, 2018 (DMH medical director did not know if DMH took any steps regarding the role of State Hospitals in response to draft TAC report; the only such example he provided regarding his own tenure as medical director was the small group home projects in Regions 8 and 9.); Mikula Dep. 103:25-105:8, Mar. 28, 2019 (no estimate of the need for PACT or an alternative to PACT).

214. Past efforts to reform the State's mental health system have been unsuccessful. *See supra* ¶¶ 212-13; *see also* Harris Dep. 29:24-30:13, Nov. 19, 2018 (SMSH psychiatrist described the ineffective efforts to reform the system to community-based care: "[B]efore I came to work with the state hospital, the – the head at the medical school, he's dead now. He fought all this all of the way through to the legislature to try to make some of these changes and it got shot down. So I mean, I don't – I don't see that I can make a change with it. . . . He had been at the medical school for like 30 years and they had this whole big plan to reformulate care in the state and I supported it big time. . . . [B]ut it got – the good ole boy system shot it down."); Trial Tr. 1175:8-1176:19, June 13, 2019 (Ladner) (describing role of Mississippi Psychiatric

Association 2010 report's lead author, the late Dr. Bo Holloman, in testifying regarding the report's recommendations before the legislature).

2. *Reforms Have Been Made in Response to Litigation.*

215. The State has not shown a history of or past commitment to deinstitutionalization, especially not outside the context of this litigation. *See* PX 363 at 46 (PEER Report, June 26, 2008) (Nine-year MAC Plan was scheduled to begin in 2003, yet as of June 2008, implementation was "only partially into year one."); Trial Tr. 2101:14-2102:11, June 25, 2019 (Allen) (Shift in funds to expand crisis services, community transition homes, MOU with Medicaid, PACT team for Region 8, expansion of supported employment all occurred after January 3, 2017 and after the onset of this litigation.).

216. State Hospital leadership are not planning further shifts in State Hospital funds or reductions of beds. Trial Tr. 2272:1-20, June 26, 2019 (Chastain) (MSH Director testifying that MSH formulates its budget anticipating that it will continue to operate the same number of beds in the next year that it does every year); Carlisle Dep. 192:21-193:18, 196:5-17, June 15, 2018 (EMSH contributed $900,000 to CMHCs as a one-time event but "I don't ever want to give any of my money away. I earned it, so I want to spend it at East Mississippi State Hospital."); Chastain Dep. 47:23-49:7, June 13, 2018 ($8 million reallocation from Mississippi State Hospital to fund grants to CMHCs is a one-time event.).

217. Though the State was aware since at least 2012 of challenges associated with discharge planning, the State's work group to improve discharge planning met for the first time in February 2019.[59] Mikula Dep. 49:22-52:11, 56:2-21, Mar. 28, 2019. Similarly, the Branch of

[59] Marc Lewis's trial testimony that the State is "working with [CMHCs] to help intensively track [individuals with multiple admissions] so that they won't be" readmitted, Trial Tr. 1696:21-1697:14, June 20, 2019, is not persuasive because it is inconsistent with the weight of other evidence. PX 406 at 118-21 (Burson Report) (Person 140 had

Coordinated Care was first set up in 2018 to, among other things, ensure that individuals being discharged from State Hospitals "understood every [housing] resource available." Trial Tr. 2030:21-2031:21, June 25, 2019 (Allen). And yet, of the 18 people referred to the Branch through the end of 2018, 12 were discharged to a homeless shelter. *Id.*

3. *Reforms Have Not Remedied the Violation of Law.*

218. Institutionalization of adults with serious mental illness has not meaningfully decreased in recent years.[60] PX 412A (Average Staffed Bed Capacity in State Hospitals[corrected]) (showing relative plateaus in numbers served, average length of stay, and State Hospital beds).

219. Indeed, at one State Hospital, beds actually *increased*. In FY 2018, five SMSH beds that had been taken offline for FY 2017 were restored, at a total cost estimated between $190,450 and at least $300,000. JX 14 at 3 (January 12, 2017 DMH Budget Request Above Legislative Budget Recommendation); PX 412A at 1 (Average Staffed Bed Capacity in State

eight hospitalizations at EMSH and an unreported number of admissions to MSH; EMSH never informed Region 7 CMHC of his May 2016 admission; his discharge plan "is essentially to 'just say no to drugs[;]'" and CMHC records indicated no follow-up between a May 2016 missed appointment and closing his case over five months later: "[t]here were no attempts to coordinate care."); Trial Tr. 615:25-618:24, 625:14-630:25, June 10, 2019 (Byrne) (Discharge planning should be adjusted after multiple admissions, but for the people Mr. Byrne reviewed discharge planning was below that standard. Person 89 was discharged three times within one year from MSH; the three discharge plans were substantively the same; MSH did not refer him to PACT after any of these admissions.); Trial Tr. 818:8-819:2, June 11, 2019 (Bell-Shambley) ("For the most part, there was not a coordination of discharge planning. I did not see consistent engagement of the community providers," which meant individuals received insufficient services on discharge and, after "a deterioration of their condition," "ultimately return[ed] to a hospital setting."); Trial Tr. 2220:4-19, June 26, 2019 (Crockett) (Region 9 does not receive regular reports identifying names of individuals who have multiple State Hospital, CSU, or ER admissions.).

[60] State expert Dr. Jeffrey Geller's testimony that Mississippi should receive an "award" for its efforts should not be afforded weight because he based his conclusions on inaccurate and irrelevant data. For example, he relied on inaccurate data regarding: (1) Mississippi's relative rate of inpatient psychiatric beds and (2) Mississippi's proportion of State mental health dollars spent on community services. His report also highlighted three forensic patients at the State Hospitals as exemplars of his conclusions, though he acknowledged that the forensic population was outside the scope of this case. Trial Tr. 2419:4-10, 2425:2-6, 2425:22-2426:2, 2426:12-16, 2427:4-19, 2428:5--2430:5, 2430:16-2431:10, 2431:11-2432:12, June 27, 2019 (Geller) (applying inaccurate data, including the data reported for Michigan instead of for Mississippi).

Hospitals [corrected]); PX 978 at 50 (Budget Request for Fiscal Year Ending June 30, 2018). Evidencing its institutional focus, the State conducted no analysis of whether that money could be spent on community-based services that would reduce the need for State Hospital beds. Breland Dep. 94:17-23, 97:10-20, 99:18-100:7, 100:17-21, Apr. 19, 2018 (DMH made Jan. 12, 2017 budget request for $190,450; Director of Administration was not "tasked with finding out" whether these beds were needed or such funds "could be spent in other ways to reduce the need" for these additional beds.); Lewis Dep. 32:22-33:2, 63:2-9, 66:5-15, May 21, 2018 (In deciding to reopen the five SMSH beds, the "primary factor" evaluated was "the waiting time for individuals and the needs for those services," yet DMH Bureau Director charged with managing inpatient facilities did not recall any discussions regarding whether the money for beds could be used for crisis stabilization services instead or whether increased availability of community-based services—such as peer bridgers—could decrease such need.)

220. There is still only a patchwork of community-based services needed to prevent unnecessary institutionalization of adults with serious mental illness. *See also supra* § V.D.1.

a. As of June 30, 2018, PACT services were available in 14 counties, a number that did not change for more than three years. *See* PX 413 (map of Mississippi counties with PACT Teams as of 6/30/2018); Mikula Dep. 26:24-27:17, Mar. 28, 2019.

b. There were eight CSUs in Mississippi in 2011, and eight CSUs in Mississippi on June 30, 2018. *Compare* JX 52 at 22 (DMH FY18 Annual Report) (map indicating 8 CSUs as of June 30, 2018), *with* PX 457 at 11 (DMH FY11 Annual Report) (map indicating 8 CSUs as of June 30, 2011).

c. The State created the CHOICE program in 2015 as part of an agreement with the United States. JX 51 at 1 (Mississippi Home Corporation, CHOICE FY 2018 Annual Report).

As of January 2018, seven regions in the State had served fewer than five clients through CHOICE. PX 416 (map showing addresses of CHOICE clients served between Feb. 2016 and Jan. 2018). In total, the State had served fewer than 350 people as of February 2018, despite estimating in 2015 that it would need at least 2,500 units to meet the need. Tr. Stip. at ¶¶ 247, 250; JX 5 at 3 (MAC 2.0 Stakeholder's Meeting Minutes, Nov. 4, 2015).

221. The State's proffered justifications for its noncompliance with Title II do not excuse that noncompliance, because the State has no comprehensive, effectively working plan for addressing those purported justifications.

a. The State asserts that it cannot expand supported employment and PACT to additional counties or regions in part because CMHCs have not applied for or accepted grant funding to do so. Trial Tr. 1583:9-15, 1585:6-17, 1645:10-22, June 19, 2019 (Hutchins) (testifying about PACT); Trial Tr. 2111:10-14, June 25, 2019 (Allen) (testifying about PACT); Trial Tr. 2334:22-2335:6, June 27, 2019 (Mikula) (testifying about supported employment). But the State could, yet has no plan to, make supported employment and PACT core services, thus requiring that they be offered by every CMHC. Trial Tr. 2344:10-2345:2, June 27, 2019 (Mikula). In addition, or in the alternative, the State could recruit additional providers to provide supported employment or PACT, but has no plan to do so. *See* Windham Dep. 86:3-12, 87:16-88:20; 89:13-22, May 29, 2018.

b. The State asserts that it could not reallocate resources because every annual appropriation designated particular sums of money for State Hospitals and particular sums for community-based services. *See* Trial Tr. 2110:17-2111:9, June 25, 2019 (Allen). But DMH requests its budget allocations and can request a shift in funds. In fact, its much-touted $8 million shift was accomplished by asking the legislature to appropriate $8 million less for the

State Hospitals, and $8 million more for community-based services. JX 15 at 87 (2019 DMH Budget Request: Program Performance Indicators and Measures).

c. The State has pointed to vague workforce challenges as inhibiting its progress towards a system that is designed to avoid unnecessary institutionalization. *See, e.g.*, Trial Tr. 1645:23-1646:17, June 19, 2019 (Hutchins); 1669:19-1670:3, June 20, 2019 (Lewis). This too is insufficient.

i. The State could address the workforce challenges it asserts by using alternative staffing, for example, using psychiatric nurse practitioners, instead of psychiatrists, on PACT teams. *See* JX 60 at 216 (PACT team staffing requirements); Trial Tr. 2215:9-11 (Crockett) (Region 9 PACT team uses nurse practitioner).

ii. The State could also take other steps that would address purported workforce shortages, like requiring that State Hospital psychiatrists spend time providing services at CMHCs. *See* PX 46 at 35 (TAC Report).

iii. Although the State set a goal to have telemedicine capabilities at all CMHCs by 2014, JX 65 at 26 (DMH Strategic Plan FY 2013-2017); Trial Tr. 1619:10-14, June 19, 2019 (Hutchins) (acknowledging in 2011 the need for telemedicine for psychiatry services where they are otherwise not available), the State ultimately scaled down its goal to merely establishing mobile crisis response teams that have the ability to use telehealth. JX 10 at 9 (DMH Strategic Plan FY 14-FY 16 End-of-Year Progress Report) (action plan to implement telemedicine by the end of FY 2014, marked completed because mobile crisis teams had the ability to tele-communicate). Since then, telemedicine has not been included in the State's strategic plans. JX 67 (DMH Strategic Plan FY 2015-FY 2017); JX 68 (FY 16-FY 18 DMH Strategic Plan); JX 69 (FY 17-FY

19 DMH Strategic Plan); PX 981 (FY 18-FY 20 DMH Strategic Plan); JX 53 (DMH FY 2019-FY 2021 Strategic Plan).

222. Because the State's progress has been minimal and has resulted in only a patchwork of service availability, access to appropriate community-based services needed to avoid unnecessary institutionalization is often achieved only through extraordinary advocacy. Trial Tr. 739:20-741:22, 743:4-12, June 11, 2019 (H.B.) (It took H.B. more than four and a half years, a call to the Governor of Mississippi, and working with leadership at DMH to find his daughter, Person 25, a place in the community. After that process, he noted: "And my biggest concern is not having the peace of mind to know that if I die, that nobody else is going to fight for her. Then she's going to wind up back in that same predicament where she was when she was ran over by that car. She'll ultimately die."); Trial Tr. 424:6-13, June 6, 2019 (VanderZwaag) (describing Person 32's conservator, who was a "strong advocate" for him).

IX. Individuals Who Are Unnecessarily Institutionalized In State Hospitals Experience Irreparable Harm.

223. In addition to the harms recognized by Congress in passing the ADA and by the Supreme Court in *Olmstead*, unnecessary hospitalizations are harmful for a number of reasons:

a. Unnecessary hospitalizations are harmful because they remove and isolate individuals from their communities, inhibit their recovery, and can result in loss of a home or custody of one's children. *See, e.g.*, PX 408 at 53 (Bell-Shambley Report) (Person 11); Trial Tr. 332:21-333:1, June 5, 2019 (Worsham) (Hospital commitments can cause people to lose "a lot of momentum in their lives. They could have even lost their apartments. They could have lost their children. They could have lost a lot by being hospitalized."); Trial Tr. 978:8-17, June 12, 2019 (Baldwin) (Person 90).

b. Unnecessary hospitalizations are harmful due to the trauma caused by hospitalization. Trial Tr. 326:25-327:2, 335:1-13, June 5, 2019 (Worsham) ("I'm terrified" of State Hospitals; "I would never want to be there, and I have made efforts in the past to stay out of them."); Trial Tr. 511:8-19, June 6, 2019 (VanderZwaag) ("[E]ven just being in the [state] hospital can be traumatizing."); Trial Tr. 851:6-21, June 11, 2019 (Bell-Shambley) (Person 1 described a State Hospital as "worse than jail."); PX 408 at 10 (Bell-Shambley Report).

c. Unnecessary hospitalizations are harmful because they lead to learned helplessness and the loss of skills, also called institutional dependence. *See, e.g.*, Trial Tr. 376:9-379:8, June 6, 2019 (VanderZwaag) (Person 38); PX 402 at 43-44 (VanderZwaag Report); PX 1083 at 4 (State Hospital evaluation noting Person 38's institutional dependence); Trial Tr. 847:10-23, 883:22-884:10, June 11, 2019 (Bell-Shambley) (Because Person 25 had been institutionalized for so long, she had lost independent living skills.); Trial Tr. 1103:17-1104:23, June 12, 2017 (Burson) (Person 132).

d. Unnecessary hospitalizations are harmful because they sap adults with SMI of their hope and resiliency and increase the likelihood of readmission. *See, e.g.*, Trial Tr. 576:20-24, June 10, 2019 (Duren) ("Q: Blair, earlier you shared some goals that you have for yourself. Did you have hope for the future before PACT? A: No, I did not. Q: Do you have hope now? A: I do."); Trial Tr. 1084:16-1085:11, 1103:17-1104:23, June 12, 2017 (Burson) (Person 132, at risk for future hospitalization, "talks about not feeling like he's able and capable to manage his health and his illness. So he gets hospitalized, but he's not leaving with a sense of self-agency that he can manage the world."); PX 406 at 81-82, 84 (Burson Report).

224. In State Hospitals, people have little choice, privacy, or autonomy; their meals, roommates, and daily schedules are dictated to them. PX 403 at 30-32, 78, 158, 161 (Baldwin

Report); PX 407 at 14-15 (Peet Report); Trial Tr. 568:20-569:13, June 10, 2019 (Duren) ("[I]t was very hard to be in a hospital because you were told, you know, when to go to bed, when it's time to eat. There is no freedom. There is no independence at all, no privacy."); Trial Tr. 737:6-738:9, June 11, 2019 (H.B.) (The State Hospital is "noisy," "crowded," and not very clean. "There virtually isn't any privacy. . . . They bathe, shower in an open shower, and they're kept during the day in a common area, and they sleep in rooms of various numbers, a dorm-type thing."); Trial Tr. 966:3-24, June 12, 2019 (Baldwin).

225. These harms can occur even during relatively brief hospitalizations. PX 404 at 9 (Drake Report); Trial Tr. 966:3-24, June 12, 2019 (Baldwin).

226. The State agrees that individuals in State Hospitals have little choice or freedom. Vaughn[61] Dep. 29:20-30:9, Mar. 29, 2018 (Community settings offer freedom that someone in a State Hospital would not have, including the freedom to "[g]o to the church of their choice, go on outings, go to the movies," "go out to eat, choose what you want to eat"—the "same things that we all have . . . .").

227. Numerous and lengthy unnecessary hospitalizations harm the family members of institutionalized individuals. Trial Tr. 742:1-18, 743:4-12, June 11, 2019 (H.B.) ("[I]t's preoccupied my entire life for the last 24 years. The stress has been terrible."); Trial Tr. 789:12-17, June 11, 2019 (C.R.) (T.M.'s mother feels sorrow when T.M. is admitted to a State Hospital).

228. It is often hard for family members to visit loved ones at State Hospitals because of long driving distances and restrictions on visitation schedules. PX 407 at 15 (Peet Report) (describing State Hospital visitation policies); Trial Tr. 735:22-736:14, June 11, 2019 (H.B.)

[61] At the time she was deposed, Veronica Vaughn was the Director of Adult Services at DMH. She also directed the Specialized Placement Option to Transition Team (SPOTT) at DMH. Vaughn Dep. 10:1-4, 17:2-18:7, Mar. 29, 2018.

(testifying his drive from the coast to MSH was a couple of hundred miles, and his drive to EMSH was at least 50 miles "if not further"); Trial Tr. 780:23-782:19, 783:18-784:11, June 11, 2019 (C.R.) (T.M.'s mother was unable to visit T.M. at the State Hospital because of distance; T.M. wrote a letter to his mother saying "I'm not sure when and if I'll ever see you again.").

229. The harms associated with numerous and lengthy hospitalizations are exacerbated by the common practice in Mississippi of holding individuals in county jails with no criminal charges and with minimal mental health treatment pending assessment for commitment and State Hospital admission. PX 404 at 16 (Drake Report); PX 488 at 3 (MSH Utilization Review Committee Meeting Minutes) (jails were the number one referral source to the civil commitment units[62] in calendar year 2016);[63] Trial Tr. 852:5-22, June 11, 2019 (Bell-Shambley) (Five people Dr. Bell-Shambley reviewed were in jail with only a commitment order; "certainly a jail is not a place for receiving mental health treatment."); Trial Tr. 915:17-921:16, June 12, 2019 (Patten) (the experience is "pure terror" for persons being civilly committed and held in jail, adding "they don't need to be in my jail or anybody's jail"); Trial Tr. 990:15-991:7, June 12, 2019 (Baldwin) (Person 117 was in jail for "approximately a week" after his family filed commitment paperwork following his second suicide attempt.); Trial Tr. 1960:11-1961:2, June 24, 2019 (Reeves) (sometimes people with serious mental illness are held in jail without treatment or medications before being admitted to a State Hospital, and this can harm individuals and make their symptoms worse); Hurley Dep. 76:11-24, Apr. 26, 2018 (It is "wrong" to hold people in jail

[62] The receiving units are for individuals who are civilly committed. Trial Tr. 2280:17-19, June 26, 2019 (Chastain).

[63] Marc Lewis's testimony that there is "confusion amongst jailers and people in the criminal system" about whether people waiting in jails are waiting for civil or criminal beds, Trial Tr. 1695:17-25, June 20, 2019, is contradicted by the State's own records. PX 488 at 3 (MSH Utilization Review Committee Minutes, May 11, 2017).

while they wait for a hospital bed, as they do in Mississippi, "[b]ecause they should be receiving treatment, not be locked in a jail cell.").

CONCLUSIONS OF LAW

I. Applicable Law

A. The Americans with Disabilities Act Prohibits Unnecessary Institutionalization of People with Disabilities.

1) The ADA "provide[s] a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).

2) In enacting the ADA, Congress stated among its Findings and Purposes that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem[;]" that "discrimination against individuals with disabilities persists in . . . critical areas [such] as . . . institutionalization[;]" and that "the Nation's proper goals regarding individuals with disabilities [include] assur[ing] . . . full participation[] [and] independent living." 42 U.S.C. § 12101(a)(2)-(3), (7).

3) Title II of the ADA prohibits discrimination by public entities, including Defendant, the State of Mississippi. 42 U.S.C. § 12131(1)(A); Trial Stip. ¶ 1. Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

4) The United States is authorized to bring this action to enforce Title II of the ADA and has complied with the statutory pre-requisites to filing suit under Title II. *See* 42 U.S.C. § 12133; Order on Mot. Summ. J., ECF No. 204, at 4-5.

5) The United States is further authorized to sue for violations of Title II of the ADA under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. §§ 1997-1997j, and

has complied with the statutory pre-requisites to filing suit under CRIPA. *See United States v. Erie Cty.*, 724 F. Supp. 2d 357, 366 (W.D.N.Y. 2010); Order on Mot. Summ. J., ECF No. 204, at 4-6.

6) The regulations implementing Title II include the "integration regulation," which requires a public entity to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (2019). The most integrated setting is "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B. at 708 (2018).

7) The regulations also require public entities to make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability unless the public entity can demonstrate that such modifications would fundamentally alter the nature of the service, program, or activity. *See* 28 C.F.R. § 35.130(b)(7) (the "reasonable modifications regulation").

8) "Unjustified isolation . . . is properly regarded as discrimination based on disability." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999). The Supreme Court explained that its holding "reflects two evident judgments." *Id.* at 600. First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* at 600 (citations omitted). Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601 (citation omitted).

9) The ADA requires public entities to provide community-based services for persons with disabilities when: (a) such services are appropriate to the needs of the individual, (b) the affected persons do not oppose community-based treatment, and (c) community-based services can reasonably be accommodated, taking into account the resources available to the public entity and the needs of other persons with disabilities. *Id.* at 607; *see* 42 U.S.C. § 12132.

10) The ADA, its regulations, and the Supreme Court's decision in *Olmstead*, thus embody the "integration mandate." This mandate requires that when a state provides services to people with disabilities, absent a fundamental alteration, it must do so "in the most integrated setting appropriate to [their] needs" if they do not oppose such setting. 28 C.F.R. § 35.130(d); *see* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b)(7)(i); *Olmstead*, 527 U.S. at 599-600, 607.

B. The ADA Applies to People at Serious Risk of Institutionalization.

11) As every court of appeals to have addressed the issue has held, beginning with the Tenth Circuit in 2003, the ADA's integration mandate applies not only to people with disabilities who are currently in institutions, but also to people with disabilities who are at serious risk of institutional placement. *Steimel v. Wernert*, 823 F.3d 902, 911-12 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263-64 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321-22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1116-17 (9th Cir. 2011), *amended by* 697 F.3d 706 (9th Cir. 2012); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003).

12) Indeed, the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." *Fisher*, 335 F.3d at 1181; *see Pitts v. Greenstein*, No. 10-635-JJB-SR, 2011 WL 1897552, at *3 (M.D. La. May 18, 2011) ("A State's program violates the ADA's integration mandate if it creates the *risk*

of segregation; neither present nor inevitable segregation is required."); *see also Steward v. Abbott*, 189 F. Supp. 3d 620, 633 (W.D. Tex. 2016) (denying motion to dismiss where plaintiffs alleged risk of institutionalization due to inability to access community-based services).

C. Public Entities Must Make Reasonable Modifications to Avoid Discrimination.

13) To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures, or practices when 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(b)(7)(i); *see also Olmstead*, 527 U.S. at 607.

14) Courts have found proposed modifications that expand existing services are reasonable, particularly when the modifications align with the jurisdiction's own stated plans and obligations. *See, e.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 280-81 (2d Cir. 2003) (upholding as a reasonable modification an order requiring agency to follow existing law and procedures); *Haddad v. Arnold*, 784 F. Supp. 2d 1284, 1304-05 (M.D. Fla. 2010) (providing a service already in state's service system to additional individuals is not a fundamental alteration); *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 344-45 (D. Conn. 2008) (plaintiffs' requested service expansion, which was consistent with defendants' publicly stated plans, was reasonable).

15) A state may violate Title II by failing to reasonably modify its service system to provide meaningful alternatives to institutional care for persons at serious risk of institutionalization. *Pashby*, 709 F.3d at 322; *see Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 609 (7th Cir. 2004) ("[A] State may violate Title II when it refuses to provide an existing benefit to a disabled person that would enable that individual to live in a more

community integrated setting."); 28 C.F.R. § 35.130(b)(7)(i), (d). "Segregation from community-based services is not cured by the fact that the community-based services exist." *Steward*, 189 F. Supp. 3d at 633.

D. Defendants Bear the Burden of Establishing the Fundamental Alteration Affirmative Defense.

16) The plaintiff's burden of identifying reasonable modifications a public entity must make to remedy or avoid discrimination is not a "heavy one." *Henrietta D.*, 331 F.3d at 280 (citing *Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131, 138 (2d Cir. 1995)). The plaintiff need only "suggest the existence of a plausible accommodation, the costs of which, facially, do not clearly exceed its benefits." *Id.* (quotation marks omitted); *see also Frederick L. v. Dep't of Pub. Welfare* (*Frederick L. II*), 364 F.3d 487, 492 n.4. (3d Cir. 2004); Order Denying Mot. Summ. J., ECF No. 204, at 6.

17) Once the plaintiff has "suggest[ed] the existence of a plausible accommodation," the burden shifts to the defendant to demonstrate, as an affirmative defense, that the modifications sought would "fundamentally alter" the nature of the services it provides. *Henrietta D.*, 331 F.3d at 280; *Frederick L. II*, 364 F.3d at 492 n.4; *see* 28 C.F.R. § 35.130(b)(7)(i).

18) States *must* make requested modifications *unless* they can prove the modifications' unreasonableness by establishing that the modifications would fundamentally alter the services they provide (i.e., the fundamental alteration defense). *Brown v. District of Columbia*, No. 17-7152, 2019 WL 2895992, at *5 (D.C. Cir. July 5, 2019) (citing *Steimel*, 823 F.3d at 914-16; *Townsend*, 328 F.3d at 517; *Frederick L. v. Dep't of Pub. Welfare* (*Frederick L. III*), 422 F.3d 151, 156-57 (3d Cir. 2005)).

19) To establish a fundamental alteration defense, a public entity can demonstrate that the requested modifications would unduly disrupt its "comprehensive, effectively working plan for placing qualified persons with . . . disabilities in less restrictive settings." *Frederick L. III*, 422 F.3d at 157; *see also Olmstead*, 527 U.S. at 605-06. An effectively working plan is one that includes and implements reasonably specific and measurable goals for addressing the unnecessary institutionalization by target dates. *Frederick L. III*, 422 F.3d at 157-58. Such goals should be "not only measurable, but strategically tailored to make a significant impact in the lives of individuals with disabilities across the state." *Jensen v. Minn. Dep't of Human Servs.*, 138 F. Supp. 3d 1068, 1072-73 (D. Minn. 2015). Moreover, an effective plan should include "a rationale for each of the metrics used, explain[] why each metric was chosen, and explain[] how each metric will adequately reflect improvement over time." *Id.* A key indicator of whether a public entity has an effectively working plan is whether the entity actually moves people to integrated settings and reduces the number of people who are unnecessarily institutionalized. *See Day v. District of Columbia*, 894 F. Supp. 2d 1, 29 (D.D.C. 2012) (finding that the defendant had not demonstrated a measurable commitment to deinstitutionalization given the negligible decrease in the nursing facility population); *see also Brown*, 2019 WL 2895992, at *11.

20) Though relevant, "budgetary constraints alone are insufficient to establish a fundamental alteration defense." *Pa. Prot. & Advocacy, Inc. v. Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005); *see also, e.g.*, *M.R.*, 697 F.3d at 736; *Frederick L. II*, 364 F.3d at 495; *Fisher*, 335 F.3d at 1183; *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 995 (N.D. Cal. 2010) (severe budget cuts did not justify termination of adult daycare services, which would place plaintiffs at serious risk of institutionalization).

21) It is not a fundamental alteration to expand services to additional persons with disabilities when a state already provides those services to some individuals with disabilities. *See Disability Advocates, Inc. v. Paterson* (*DAI I*), 598 F. Supp. 2d 289, 335-36 (E.D.N.Y. 2009) ("Where individuals with disabilities seek to receive services in a more integrated setting—and the state *already provides* services to others with disabilities in that setting—assessing and moving the particular plaintiffs to that setting, in and of itself, is not a 'fundamental alteration.'"); *see also Townsend v. Quasim*, 328 F.3d 511, 519 (9th Cir. 2003) ("*Olmstead* did not regard the transfer of services to a community setting, without more, as a *fundamental* alteration. Indeed, such a broad reading of fundamental alteration regulation would render the protection against isolation of the disabled substanceless.").

II. Mississippi is Violating Title II of the ADA.

22) Mississippi is violating Title II of the ADA by failing to provide community-based services to qualified people with serious mental illness, who do not oppose receiving such services in the community and for whom community-based services are appropriate. Instead of providing qualified people with serious mental illness appropriate services in community-based settings that they do not oppose, the State overly relies on State Hospitals to provide services. *See, e.g.*, *Disability Advocates, Inc. v. Paterson* (*DAI II*), 653 F. Supp. 2d 184, 187-88 (E.D.N.Y. 2009) (finding violation of ADA where approximately 4,300 people with mental illness, virtually all of whom were qualified and appropriate for and did not oppose integrated placements, were nonetheless being served in segregated settings), *vacated on other grounds sub nom. Disability Advocates, Inc. v. N.Y. Coal. for Quality Assisted Living, Inc.*, 675 F.3d 149 (2d Cir. 2012).

A. Many People with Serious Mental Illness Are Institutionalized in Mississippi State Hospitals or Are at Serious Risk of Such Institutionalization Because They Do Not Receive Appropriate Community-Based Treatment.

1. State Hospitals Are Institutions that Segregate People with Serious Mental Illness from the Community.

23) Mississippi's state psychiatric hospitals are segregated institutions. Trial Stip. ¶ 11; *see also* 42 U.S.C. § 1997(1) (defining a State facility for individuals with mental illness as an "institution"); *Olmstead*, 527 U.S. at 593 (plaintiffs challenged institutionalization in state psychiatric hospital units). They do not "enable[] individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B at 708; *see supra* Findings of Fact § III.

2. People with Serious Mental Illness in Mississippi Are Qualified Individuals with Disabilities and Are Appropriate to Receive Community-Based Services.

24) Title II of the ADA provides that "'qualified individual[s] with a disability' may not 'be subjected to discrimination.'" *Olmstead*, 527 U.S. at 602 (quoting 42 U.S.C. § 12132) (alteration in original). People with disabilities[64] are "qualified" if they "'mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.'" *Olmstead*, 527 U.S. at 602 (quoting 42 U.S.C. § 12131(2)) (alteration in original). People with serious mental illness who have been, or may in the future be, admitted to State Hospitals and who are eligible for community-based services in Mississippi's public health system are "qualified" individuals with disabilities under the ADA. 42 U.S.C. § 12131(2); *Olmstead*, 527 U.S. at 602.

25) Additionally, people with serious mental illness in Mississippi who are or may in the future receive treatment in State Hospitals are appropriate for the range of community-based

[64] Individuals admitted to or at serious risk of entry into State Hospitals are persons with disabilities under the ADA because they have serious mental illnesses such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. 42 U.S.C. § 12102(1)-(2); Trial Stip. ¶ 13.

mental health services that help people avoid hospitalization. *See, e.g.*, *Olmstead*, 527 U.S. at 602, 607; *Vaughn v. Wernert*, 326 F. Supp. 3d 624, 636-37 (S.D. Ind. 2018) (finding "appropriate" a plaintiff whose doctors testified could live in the community with appropriate services but who nevertheless remained in a nursing facility because the state's own policies prevented her from receiving services in the community); *Cota*, 688 F. Supp. 2d at 994 (appropriateness prong satisfied where plaintiffs' individual plans of care documented their need for specific community services and those services were "critical to their ability to avoid institutionalization, and to remain in a community setting"); *see supra* Findings of Fact §§ IV, V.[65]

26) The pertinent question regarding appropriateness is not whether, on the day of admission, an institution was an appropriate setting in which to treat the individuals. *See supra* Findings of Fact § V.E. (discussing the State's Clinical Expert evidence). Rather, the pertinent question is whether the individuals could have received community-based services that would have helped them avoid institutionalization or shortened their period of institutionalization. *See Olmstead*, 527 U.S. at 607; *Cota*, 688 F. Supp. 2d at 994; *DAI II*, 653 F. Supp. 2d at 256-58; *see also supra* Findings of Fact § V.E.[66] The latter inquiry properly accounts for individuals who are

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[65] It should be noted that the United States need not rely on the State's treatment professionals to demonstrate appropriateness for community-based services. *See Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 290-91 (E.D.N.Y. 2008) (rejecting the argument that the state's treatment professionals must be the ones to make an appropriateness determination); *see also, e.g.*, *Day*, 894 F. Supp. 2d at 23-24 (holding same, noting that "lower courts have universally rejected the absolutist interpretation proposed by defendants"); *Long v. Benson*, No. 4:08cv26, 2008 WL 4571904, at *2 (N.D. Fla. Oct. 14, 2008) (noting that the right to receive services in the community would become illusory if the state could deny the right by refusing to acknowledge the appropriateness of community placement); *Frederick L. v. Dep't of Pub. Welfare* (*Frederick L. I*), 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001) (finding that states cannot avoid the integration mandate by failing to make recommendations for community placement).

[66] Expert testimony that relies upon a flawed methodology deserves little weight. *See Contango Operators, Inc. v. United States*, 9 F. Supp. 3d 735, 759 (S.D. Tex. 2014) (crediting damages expert who the court found applied a "more reliable" methodology than conflicting expert), *aff'd sub nom. Contango Operators, Inc. v. Weeks Marine, Inc.*, 613 F. App'x 281 (5th Cir. 2015); *see also supra* Findings of Fact § V.E.

not currently institutionalized but who are at serious risk of institutionalization due to the State's insufficient provision of the community-based services that they need to avoid reaching the point where hospitalization may become necessary.[67] *See, e.g.*, *Fisher*, 335 F.3d at 1181; *Cota*, 688 F. Supp. 2d at 994 (discrimination occurred when services "critical to [plaintiffs'] ability to avoid institutionalization" were not available); *Marlo M. ex rel. Parris v. Cansler*, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) ("[T]ermination of funding by Defendants will force Plaintiffs from their present living situations, in which they are well integrated into the community, into group homes or institutional settings."). The inquiry also properly accounts for individuals who are institutionalized longer than necessary due to the lack of appropriate discharge planning and the community-based services that they need to return home. *See Olmstead*, 527 U.S. at 607. People with serious mental illness in Mississippi experience such unnecessary institutionalization and serious risk of unnecessary institutionalization. *See supra* Findings of Fact § V.

B. Adults with Serious Mental Illness in Mississippi Do Not Oppose Receiving Services in the Community.

27) The State must provide services in the most integrated setting appropriate, unless the qualified person opposes receiving services in that setting. *Olmstead*, 527 U.S. at 607 (Title II of the ADA requires that states provide community-based treatment for qualified individuals where "the affected persons do not oppose" community-based treatment); *see* 42 U.S.C. § 12201(d) ("Nothing in this chapter shall be construed to require an individual with a disability to

[67] Whether the State or chancery courts are misapplying commitment criteria or whether those criteria have been met is outside of this inquiry. Rather, the question is whether the State is violating the ADA, separate and apart from the commitment process, by failing to provide services that people with serious mental illness need to avoid the decline in mental health that leads to the initial institutionalization or unnecessarily long institutionalization. 28 C.F.R. § 35.130(b)(7), (d).

accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept.”).

28) With few exceptions, adults with serious mental illness in Mississippi do not oppose receiving services in the community rather than in State Hospitals. *See supra* Findings of Fact § VI. The United States has therefore carried its burden on *Olmstead*'s second element.

C. The State Can Make Reasonable Modifications to Accommodate Community-Based Treatment and Prevent Unnecessary Hospitalizations.

29) The final prong to demonstrate a violation of the integration mandate is to show that the state can make reasonable modifications to its service system to accommodate placement in the community. *Olmstead*, 527 U.S. at 607. A plaintiff carries its burden on this element once it “suggest[s] the existence of a plausible accommodation, the costs of which, facially, do not clearly exceed its benefits.” *Henrietta D.*, 331 F.3d at 280 (citing *Borkowski*, 63 F.3d at 138) (quotation marks omitted); *see also Frederick L. II*, 364 F.3d at 492 n.4.

30) The United States has identified modifications Mississippi can make to its existing service design and administration to accommodate community-based treatment and prevent unnecessary hospitalizations. In summary, these are: (1) expanding existing community mental health services that prevent hospitalization to ensure that those services are available statewide and are provided to those who need them; (2) identifying eligible adults with serious mental illness who need community-based services to avoid entering State Hospitals; and (3) implementing effective discharge planning and diversion practices to prevent readmissions. *See* Opp. Mot. Summ. J., ECF No. 153, at 7-8.

31) It is reasonable for Mississippi to modify its policies, procedures, and practices to expand existing community mental health services that prevent hospitalization—namely, PACT, supported housing, community support services, supported employment, peer support, mobile

crisis services, and crisis stabilization units—because these services already exist in some quantities in some parts of the State. *See supra* Findings of Fact §§ IV, VII.A. Proposed modifications that expand existing services are reasonable. *See, e.g.*, *DAI I*, 598 F. Supp. 2d at 335-36 ("Where individuals with disabilities seek to receive services in a more integrated setting – and the state *already provides* services to others with disabilities in that setting – assessing and moving the particular plaintiffs to that setting, in and of itself, is not a 'fundamental alteration.'"); *see also Townsend*, 328 F.3d at 518-19 ("*Olmstead* did not regard the transfer of services to a community setting, without more, as a *fundamental* alteration. Indeed, such a broad reading of fundamental alteration regulation would render the protection against isolation of the disabled substanceless."). This is the case particularly when the modifications align with the jurisdiction's own stated plans and obligations, as it does here. *See, e.g.*, *Henrietta D.*, 331 F.3d at 280-81; *Messier*, 562 F. Supp. 2d at 344-45; *see supra* Findings of Fact §§ IV, VII.A.

32) Moreover, the State has a separate and independent legal obligation under Medicaid to expand existing community-based mental health services for Medicaid beneficiaries. When a State participates in the Medicaid program and includes services in its Medicaid State Plan, the State is obligated to ensure that those services are available with reasonable promptness statewide to all individuals who meet Mississippi's Medicaid eligibility criteria. 42 U.S.C. § 1396a(a)(8), 42 C.F.R. § 435.930 (2019) (with reasonable promptness); 42 U.S.C. § 1396a(a)(1), 42 C.F.R. § 431.50 (2019) (statewide). Mississippi has included mobile crisis, crisis stabilization services, PACT, community support services, and peer support in its State Plan. *See supra* Findings of Fact § VII.A.2. Yet Mississippi acknowledges geographic gaps in the availability of services. *See id.* § V.D.1. Because the State already must make these services accessible

statewide, 42 U.S.C. § 1396a(a)(1), 42 C.F.R. § 431.50, meeting this obligation is inherently reasonable.

33) Mississippi can implement the modification of expanding existing community-based services in a resource-efficient and data-driven manner. It can ensure that many people who are qualified and appropriate for and do not oppose community-based treatment are provided services in their communities rather than in segregated, institutional settings by identifying individuals likely to need intensive services in order to connect them with those services. While Mississippi has access to the data and information necessary to identify people who need community-based services to avoid State Hospital admission, it does not use its data to identify this population or connect them with services. *See supra* Findings of Fact § VII.B. It is reasonable for Mississippi to do so. *See DAI II*, 653 F. Supp. 2d at 267-68, 280-81.

34) It is also reasonable for Mississippi to modify its policies, procedures, and practices to implement effective discharge planning and diversion practices to prevent readmissions. Mississippi DMH recognizes that effective discharge planning—including close coordination between State Hospitals and community providers before discharge—can prevent State Hospital admissions, and such effective discharge planning is consistent with the State's purported policy. *See supra* Findings of Fact § VII.C. It is reasonable for the State to implement effective discharge planning that comports with its own standards. *See, e.g.*, *Henrietta D.*, 331 F.3d at 280-81; *Messier*, 562 F. Supp. 2d at 344-45.

35) The United States has demonstrated that the costs of its requested modifications "facially, do not clearly exceed [their] benefits." *Henrietta D.*, 331 F.3d at 280 (citing *Borkowski*, 63 F.3d at 138) (quotation marks omitted). To the contrary, the evidence shows that Mississippi can save money by implementing the modifications requested here. *See supra*

Findings of Fact § VII.A.3. The evidence shows that serving people in the community is more cost-effective than institutional treatment, or, at the very least, as the State's experts conceded, the costs of serving individuals in the community and in the State Hospitals are comparable. *See supra* Findings of Fact § VII.A.3.iv; *see, e.g.*, *Haddad*, 784 F. Supp. 2d at 1303-04, 1307 (finding requested in-home services to be a reasonable accommodation given the cost-neutrality or cost-saving of in-home services compared with nursing home placement); *Grooms v. Maram*, 563 F. Supp. 2d 840, 855-56 (N.D. Ill 2008) (same); *see also DAI II*, 653 F. Supp. 2d at 306. Moreover, Mississippi can save money by serving a greater proportion of people in the community and by maximizing Medicaid reimbursement of community-based services, even while maintaining a "range of facilities," *Olmstead*, 527 U.S. at 597, and even if an initial outlay of funds is required to expand non-institutional services. *See supra* Findings of Fact § VII.A.3; *see also Fisher*, 335 F.3d at 1183 ("If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed."). The United States need not demonstrate more, as the burden to demonstrate unreasonableness (*i.e.*, a fundamental alteration) lies with the defendant. *E.g.*, *Brown*, 2019 WL 2895992, at *5 (citing *Steimel*, 823 F.3d at 914-16; *Townsend*, 328 F.3d at 517; *Frederick L. III*, 422 F.3d at 156-57); *see infra*, Conclusions of Law § II.D. (discussing the fundamental alteration defense).

36) Because Mississippi can reasonably modify its system to accommodate the relief the United States seeks, the United States has established a prima facie violation of Title II of the ADA.

D. Mississippi Has Not Demonstrated a Fundamental Alteration Defense.

37) The State would not violate the integration mandate if it could show, as an affirmative defense, that the requested modifications would "fundamentally alter" its service system. 28 C.F.R. § 35.130(b)(7)(i). To this end, a public entity can show that it has developed and is implementing a comprehensive and effective plan to serve adults with serious mental illness in the community (*i.e.*, an "*Olmstead* Plan"). *Olmstead*, 527 U.S. at 605-06; *see Frederick L. III*, 422 F.3d at 155-59.

38) Mississippi has not demonstrated that it has an *Olmstead* Plan at all. The Mississippi DMH Deputy Executive Director testified not only that he has "never seen" a Mississippi Olmstead Plan but that such a plan would be "useless." *See supra* Findings of Fact § VIII.A. Because the State's evidence is at best inconsistent as to whether an *Olmstead* Plan even exists in Mississippi, the State has failed to demonstrate by a preponderance of the evidence that it has an *Olmstead* Plan.

39) Even assuming that the collection of documents the DMH Executive Director testified constitute Mississippi's *Olmstead* Plan actually is the State's plan, these documents do not include measurable goals "strategically tailored to make a significant impact in the lives of individuals with disabilities across the state," for which the State "provides a rationale for each of the metrics used, explains why each metric was chosen, and explains how each metric will adequately reflect improvement over time." *Jensen*, 138 F. Supp. 3d at 1072; *see also Frederick L. III*, 422 F.3d at 157; *see supra* Findings of Fact § VIII.B. Moreover, the State has failed to show that its plans have actually resulted in reduced institutionalization. *See Day*, 894 F. Supp. 2d at 29; *see also Brown*, 2019 WL 2895992, at *11; *see supra* Findings of Fact §§ VIII.B., C.; *cf. Frederick L. III*, 422 F.3d at 156 (crediting a state's strong past commitment to

deinstitutionalization but finding that the state's "vague assurance" in lieu of "measurable goals for community integration" was insufficient to demonstrate a fundamental alteration defense).

40) In any event, Mississippi has not demonstrated that it has facilitated sufficient access to its existing community mental health service system, steadily increased the capacity of that system over the years, or steadily decreased the number of people continuing to cycle into State Hospitals. Rather, the changes Mississippi has made are minimal, were almost entirely undertaken since the United States completed its investigation or filed the complaint in this action, and have had little to no demonstrable effect on the number of people institutionalized. *See Benjamin v. Dep't of Pub. Welfare*, 768 F. Supp. 2d 747, 756 (M.D. Pa. 2011) ("Considering the absence of concrete benchmarks for deinstitutionalization in the contingency-ridden Plan, no record of actual implementation of the Plan, and a history of unnecessary segregation of and discrimination against institutionalized persons, we cannot conclude that [the public entity] has complied with or will comply with the integration mandates of the ADA and RA."); *see supra* Findings of Fact § VIII.C. In addition, "in light of the hardship daily inflicted upon patients through unnecessary . . . institutionalization," as demonstrated by the evidence in this case, Mississippi's "announced commitment" to serving people in their communities is an "insufficient guarantor[]" of future ADA compliance; as such, it cannot stand in place of "an adequately specific comprehensive plan" with demonstrated results. *See Frederick L. III*, 422 F.3d at 158-59.

41) The facts in this case are distinct from those in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), and *Arc of Washington State, Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005), where the Ninth Circuit found California and Washington had comprehensive, effectively working plans for deinstitutionalization and provision of community services to people with

developmental disabilities. In *Sanchez*, the record showed that California had been steadily expanding access to the home and community-based services program at issue for at least a decade leading up to the filing of the litigation, and that over the four years prior to the litigation, California had significantly reduced the proportion of individuals institutionalized. 416 F.3d at 1067. Similarly, in *Arc of Washington*, Washington was found to have maximized access to its existing waiver program for home- and community-based services while expanding its capacity steadily since 1983 by increasing both available waiver slots and program funding; simultaneously, the state kept institutional funding constant and was able to significantly reduce the population of institutionalized people. 427 F.3d at 621.

42) In sum, Mississippi has failed to prove that it has a comprehensive, effectively working plan to serve people with serious mental illness in their communities. *See Frederick L. III*, 422 F.3d at 158-59; *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 381-82 (3d Cir. 2005); *Hampe v. Hamos*, 917 F. Supp. 2d 805, 821-22 (N.D. Ill. 2013).

43) Finally, the State has not established that implementing the modifications the United States requests would fundamentally alter its service system. It appears that the State has only raised an affirmative defense as to one of the United States' three proposed modifications: the expansion of community-based mental health services. *See* Miss. Pretrial Br. at 17, 28. As an initial matter, the services the United States is seeking in this case already exist in Mississippi, albeit insufficiently. *See DAI I*, 598 F. Supp. 2d at 335-36. And, although "budgetary constraints alone are insufficient to establish a fundamental alteration defense," *Pa. Prot. & Advocacy, Inc.*, 402 F.3d at 380; *see also M.R.*, 697 F.3d at 736 (same); *Fredrick L. II*, 364 F.3d at 495; *Cota*, 688 F. Supp. 2d at 995, the State has not demonstrated that expanding existing community-based mental health services would be prohibitively expensive. *See supra* Findings

of Fact § VII.A.3. Rather, the weight of the evidence suggests that expanding community-based services, while still maintaining a "range of facilities," *Olmstead*, 527 U.S. at 597, can save Mississippi money.[68] *See supra* Findings of Fact § VII.A.3, Conclusions of Law § II.C.

III. Declaratory and Injunctive Relief is Warranted.

44) Declaratory relief is appropriate both to resolve disputed legal rights as well as to determine that such rights were violated by a defendant's past conduct. *See Richards Grp., Inc. v. Brock*, No. 3:06-CV-0799-D, 2008 WL 2787899, at *2 (N.D. Tex. July 18, 2008) (under the Declaratory Judgement Act, courts "may declare the rights and other legal relations of any interested party seeking such declaration," and have "broad discretion" to do so) (internal quotation marks omitted) (quoting 28 U.S.C. § 2201) (citing *Torch Inc. v. LeBlanc*, 947 F.2d 193, 194 (5th Cir. 1991)). Here, the Court should enter a declaratory judgment that the State is in violation of the ADA because the State does not provide services in the most integrated setting to qualified people with serious mental illness who are unnecessarily institutionalized in State Hospitals in Mississippi or are at serious risk of such unnecessary institutionalization.

45) Injunctive relief is also warranted. Upon finding the State liable for violations of federal statutes, this Court has ample authority to enter a final injunction that is targeted to remedy the violations. *See* Fed. R. Civ. P. 65. "To obtain permanent injunctive relief, a plaintiff

[68] Mississippi also points to the Institutions for Mental Diseases ("IMD") exclusion as a reason why shifting funds away from its State Hospitals and toward community-based services would be so prohibitively expensive as to constitute a fundamental alteration. Miss. Pretrial Br., ECF No. 208, at 22. The IMD exclusion is a part of the Medicaid Act that prohibits states from receiving federal Medicaid dollars to reimburse services provided in institutions like State Hospitals. *See* 42 U.S.C. § 1396d(a)(B). Combined with the availability of Medicaid reimbursement for community-based mental health services since 1981, federal law actually renders community-based services less expensive than institutional services, taking into account the federal Medicaid match for state dollars spent in the community; that was, in fact, its intended purpose. *See Olmstead*, 527 U.S. at 601; *see also supra* Findings of Fact § VII.A.3. Further, the IMD exclusion has been part of the U.S. Code since the enactment of the Medicaid program in 1965. *See* Pub. L. No. 89-97, § 121(a), 79 Stat. 343, 351-52 (1965). Other states, working under the same federal laws, policies, regulations, and funding decisions as Mississippi, have been able to provide community-based services that prevent unnecessary hospitalization. *See supra* Findings of Fact § VII.D. Thus, the Medicaid reimbursement system does not prevent Mississippi from doing the same.

must demonstrate: '(1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.'" *ITT Educ. Servs., Inc. v. Arce*, 533 F.3d 342, 347 (5th Cir. 2008) (quoting *eBay, Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006)). The United States meets this standard.

46) Mississippi's actions have caused irreparable injury to people with serious mental illness who are in State Hospitals or at serious risk of being admitted to such facilities. The irreparable injury resulting from Mississippi's ongoing failure to provide people with serious mental illness with appropriate community-based treatment is severe and ongoing. *See, e.g.*, *M.R.*, 697 F.3d at 732-33 (upholding preliminary injunction and holding serious risk of institutionalization to be irreparable harm); *Cota*, 688 F. Supp. 2d at 985, 997-98 (irreparable harm where thousands of people were placed at risk of institutionalization as a result of changes in eligibility criteria for adult day healthcare due to state budget cuts); *Marlo M. ex rel. Parris v. Cansler*, 679 F. Supp. 2d at 638 (finding irreparable harm even if institutionalization were only temporary and recognizing the "regressive consequences" that such placements have on people); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1176 (N.D. Cal. 2009); *Crabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008) (finding that unnecessary institutionalization "would be detrimental to [plaintiffs'] care, causing, *inter alia*, mental depression, and for some Plaintiffs, a shorter life expectancy or death"); *Long v. Benson*, No. 4:08cv26-RH/WCS, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008) (finding irreparable harm where person would be forced to enter a nursing home, recognizing the "enormous psychological blow" that such a placement would cause, and noting that "because of the very

substantial difference in [plaintiff's] perceived quality of life in the apartment as compared to the nursing home, each day he is required to live in the nursing home will be an irreparable harm").

47) The *Olmstead* Court itself recognized the harm that results from unnecessary institutionalization: "[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead*, 527 U.S. at 601. Many people with serious mental illness remain unnecessarily institutionalized in State Hospitals, and more have been repeatedly institutionalized and subjected to lengthy hospital stays. Many of these people have suffered regression and deterioration. They need, but are not receiving, community-based mental health services that would allow them to gain skills, become more independent, and function outside of an institution. They are deprived of community and family connections and the opportunity to participate in day-to-day community activities, which constitutes segregation and a form of discrimination.

48) In addition, the violation of federal laws enacted to protect the health, safety, welfare, and civil rights of vulnerable people is itself a form of harm. *See, e.g.*, *EEOC v. Cosmair, Inc.*, 821 F.2d 1085, 1090 (5th Cir. 1987) ("[W]hen a civil rights statute is violated, 'irreparable injury should be presumed . . . .'") (quoting *United States v. Hayes Int'l Corp.*, 415 F.2d 1038, 1045 (1969)).

49) For purposes of injunctive relief, an "adequate remedy at law" exists when damages can make plaintiff whole. *See, e.g.*, *Janvey v. Alguire*, 647 F.3d 585, 600 (5th Cir. 2011). The ADA violation established in this case—a failure to provide services in the most integrated setting appropriate to people with serious mental illness in Mississippi—cannot be remedied without expanding access to the community-based services that would allow people

with serious mental illness in Mississippi to avoid unnecessary institutionalization. *See Vaughn v. Wernert* (*Vaughn II*), 357 F. Supp. 3d 720, 724 (S.D. Ind. 2019) (Plaintiff "has made clear throughout the course of this lawsuit that the only relief she seeks is to receive care at home. Defendants have not identified, and the Court is unaware of, any remedy at law that could accomplish that result. There is no remedy at law to compensate [Plaintiff] for her injuries, and this element weighs heavily in favor of injunctive relief."). This element therefore weighs in favor of an injunction.

50) The balance of hardships also weighs in favor of an injunction. Mississippi's stated interests in this case—administering its mental health services system and Medicaid program, and the cost of implementing the requested modifications—do not outweigh the irreparable harm people with serious mental illness would face absent the requested relief. *See supra* Findings of Fact § IX. A public entity "can never have a legitimate interest in administering [a] program in a manner that violates federal law." *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 471 (5th Cir. 2017) (upholding preliminary injunction in case under the Medicaid Act, discussing Louisiana Department of Health and Hospitals' interest in administering the Louisiana Medicaid program); *see also Harrison v. Phillips*, No. 3:19-CV-1116-B, 2019 WL 2869741, at *11 (N.D. Tex. July 3, 2019) (granting preliminary injunction in *Olmstead* case, stating that Texas agency could not have a legitimate interest in administering Medicaid program in a manner that violates federal law).[69]

51) Finally, the public interest would be served by an injunction here. "[T]here is no legitimate public interest in allowing" public entities to violate federal law. *Gee*, 862 F.3d at

[69] The standard for a permanent injunction is essentially the same as for a preliminary injunction, except that the plaintiff must show actual success on the merits rather than a mere likelihood of success; these proposed findings therefore cite cases evaluating requests for preliminary and permanent injunctions when discussing the elements for a permanent injunction. *See Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 546 n.12 (1987).

472; *see also Blue Bell Creameries, L.P. v. Denali Co.*, Civil Action No. H-08-0981, 2008 WL 2965655, at *7 (S.D. Tex. July 31, 2008) (noting, in the preliminary injunction context, that "the public interest is served whenever state and federal laws are enforced"). By contrast, "[t]he public has a strong interest in eliminating discrimination and in enforcing the ADA . . . ." *Vaughn II*, 357 F. Supp. 3d at 724; *see also M.R.*, 697 F.3d at 738-39 (reversing denial of preliminary injunction in light of "the statutorily declared policy of the state in favor of the services [plaintiffs] seek to preserve"). And, as the Fifth Circuit "emphasize[d]," "there is a legitimate public interest in safeguarding access to health care for those eligible for Medicaid." *Gee*, 862 F.3d at 472 (quoting *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 659 (9th Cir. 2009), *vacated and remanded on other grounds*, 565 U.S. 606 (2012)) (quotation marks omitted). In sum, the standard for a permanent injunction has been met here.

52) The scope of the relief granted depends upon the scope of the violation proven at trial. *Lewis v. Casey*, 518 U.S. 343, 357 (1996).

53) Injunctive relief requiring Mississippi to modify its mental health service system with respect to all qualified people with serious mental illness in the state is warranted because the United States has shown that the State's failure to provide services in the most integrated setting appropriate is generally applicable to this population. *See, e.g.*, *DAI II*, 653 F. Supp. 2d at 312-14; *Messier*, 562 F. Supp. 2d at 345; *see also In re District of Columbia*, 792 F.3d 96, 101 (D.C. Cir. 2015) (rejecting request for interlocutory review of class certification where *Olmstead* claim could meet test under Rule 23(b)(2) that "final injunctive relief . . . [would be] appropriate respecting the class as a whole").

54) Judgment should be entered for the United States. The Parties should meet and confer, for a period of time to be set by the Court, to propose a remedial order consistent with

this findings of fact and conclusions of law and shall submit an agreed-upon proposed remedial order at the end of the period. The proposed remedial order should address steps Mississippi shall take to (1) expand existing community mental health services that prevent hospitalization to ensure that those services are available statewide and are provided to those who need them to avoid unnecessary institutionalization; (2) identify eligible adults with serious mental illness who need community-based services to avoid entering State Hospitals; and (3) implement effective discharge planning and diversion practices to prevent readmissions.

55) If the Parties cannot agree upon a proposed remedial order in full, then by the end of the period set by this Court, the Parties should jointly submit any portion(s) of a proposed remedial order on which they can agree, and each submit for consideration by the Court a proposed remedial order regarding remaining issues on which they cannot agree.

Dated: July 22, 2019

D. MICHAEL HURST, JR.
United States Attorney
Southern District of Mississippi

MITZI DEASE PAIGE [MS BAR 6014]
CANDACE MAYBERRY
Assistant United States Attorneys
501 E. Court Street, Suite 4.430
Jackson, MS 39201
Telephone: (601) 973-2840
mitzi.paige@usdoj.gov
candace.mayberry@usdoj.gov

ERIC S. DREIBAND
Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

REGAN RUSH
Deputy Chief
Special Litigation Section

/s/ *Deena Fox*____________
DEENA FOX [DC Bar 992650]
JORGE CASTILLO
PATRICK HOLKINS
ASHLEY MCDONALD
MATHEW SCHUTZER
HALEY VAN EREM
LINDSEY WEINSTOCK
Trial Attorneys
Special Litigation Section
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Avenue, N.W. - PHB
Washington, DC 20530
Telephone: (202) 305-1361
Deena.fox@usdoj.gov

CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2019, I electronically filed the foregoing with the Clerk of Court using the ECF system, which sent notification of such filing to all counsel of record.

/s/ _*Deena Fox*___________
DEENA FOX