UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	**Civil Action No. 74-285 (TFH)**
	)	
ADRIAN M. FENTY, et al.,	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' MOTION TO VACATE
DECEMBER 12, 2003 CONSENT ORDER AND TO DISMISS ACTION

Defendants (hereinafter "the District"), by and through undersigned counsel and pursuant to Federal Rule of Civil Procedure 60(b)(5), respectfully move this Court to vacate the December 12, 2003 Consent Order ("Consent Order")[1] and dismiss this case. Because the District has remedied the original violation of law, "continued enforcement of the [consent] order is not only unnecessary, but improper" under the Supreme Court's recent decision in *Horne v. Flores*, 129 S. Ct. 2579, 2595 (2009).

The District's mental health system today bears little resemblance to the one that existed when this litigation began more than 35 years ago. In 1974, Plaintiffs charged the District[2] with violating the Ervin Act, 21 D.C. CODE §§ 501 *et seq.*, by unnecessarily hospitalizing mental health consumers in Saint Elizabeths Hospital (the "Hospital") when they could be treated in less restrictive environments. *See Dixon v. Weinberger*, 405 F. Supp. 974, 979 (D.D.C. 1975)

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[1] The District also moves to vacate any and all other orders that remain in effect, including the March 28, 2001 Final Court-Ordered Plan and the May 23, 2002 Order appointing the court monitor.

[2] Originally, both the District and the United States were defendants, as both shared responsibilities under the Ervin Act. This joint responsibility ended on October 1, 1987, when Congress transferred authority over Saint Elizabeths to the District of Columbia. The federal government was formally dismissed from the lawsuit in 1982.

("*Dixon* Decree").[3] At that time, the District's primary method of serving the mentally ill was to house and treat them in the Hospital—which was then a massive facility with over 3,600 patients. There were few, if any, community-based alternatives for mentally ill individuals who could have been treated in less restrictive environments. It was on this ground that the Court held, in 1975, that the District had violated the law by "failing to place plaintiffs and members of their class [in] . . . less restrictive alternatives to the Hospital." *Id*.

Today, it is no exaggeration to state that the District's mental health service delivery system has been radically transformed. The District has shifted primary treatment of the mentally ill from the Hospital to community-based alternatives. In so doing, the District has reduced admissions to Saint Elizabeths by 77% since 2003 alone. Overall, the Hospital census has been reduced from thousands to a mere 370. Indeed, at present, more than 98% of the District's public mental health consumers are treated in the community.

These results are not happenstance but, rather, are the product of significant long-term changes in practice and law. As the indisputable facts demonstrate, the District has remedied the original Ervin Act violation and is entitled to dismissal of this suit. There simply are no continuing violations that support continuation of this Court's jurisdiction. This fact, standing alone, is sufficient ground to dismiss this action.

Additionally, the District's remediation of the original systemic legal violations, as well as the current economic and fiscal conditions facing the District, are the very type of "changed circumstances" recognized by the Court in *Horne*, 129 S. Ct. at 2593, that make continued enforcement of a consent decree inequitable. Thus, these "changed circumstances" also provide an independent ground for dismissal of this action.

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[3] The Ervin Act is officially entitled the "Hospitalization of the Mentally Ill Act." *See* 21 D.C. CODE § 501.

Moreover, the Court should vacate the Consent Order because, by its own terms, the District has complied or substantially complied with the exit criteria established by the Court. (*See* Consent Order at 2 (providing that the District may move to dismiss when it has demonstrated "substantial compliance" with the exit criteria).) Indeed, the Consent Order specifically provides that once substantial compliance is achieved, and in the interests of justice, the case should be dismissed. (*Id.*) As discussed briefly herein and in more detail in the accompanying appendix, of the nineteen (19) exit criteria, the court monitor has already recommended inactive status on six (6). The District has substantially complied with another seven and one half (7.5). And six and one half (6.5) criteria, including one on inactive status, are moot because they relate specifically to services provided to children, who no longer qualify as members of the *Dixon* class because they are not at risk of being hospitalized at Saint Elizabeths.

In short, and as fully explained in the accompanying memorandum, the District has created a mental health system that provides treatment in the least restrictive environment through a broad range of community-based services and supports. As such, after more than three decades, the time has come to return full management of the District's mental health system to the District's elected officials. For these reasons, the Consent Order should be vacated, and this case should be dismissed. A proposed Order is submitted herewith.

In the alternative, at the very least, the Court should discharge all provisions of the Consent Order and any other orders now in force, to the extent that they are no longer necessary to remedy ongoing violations of the Ervin Act, as described in the *Dixon* Decree.[4]

[4] Counsel for the District exchanged telephone messages with Plaintiffs' counsel in an attempt to confer regarding this motion. Counsel for the District also emailed Plaintiffs' counsel requesting a telephone conference to determine, in good faith, whether any areas of disagreement could be narrowed. Plaintiffs did not respond to the email prior to filing. The District assumes that the Plaintiffs do not consent.

Respectfully submitted,

Dated: September 4, 2009

EUGENE ADAMS
Principal Deputy Attorney General for
the District of Columbia

GEORGE C. VALENTINE
Deputy Attorney General
Civil Litigation Division

/s/ Ellen A. Efros
ELLEN A. EFROS [250746]
Chief, Equity I
Telephone (202) 442-9886
ellen.efros@dc.gov

/s/ Grace Graham
GRACE GRAHAM [472878]
Assistant Attorney General
Telephone (202) 442-9784
Facsimile (202) 727-3625
grace.graham@dc.gov

/s/ Sarah Sulkowski
SARAH SULKOWSKI [493235]
Assistant Attorney General
441 Fourth Street N.W., Suite 600 South
Washington, D.C. 20001
Telephone (202) 724-6627
Facsimile (202) 730-1454
sarah.sulkowski@dc.gov

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MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO VACATE DECEMBER 12, 2003 CONSENT ORDER AND TO DISMISS ACTION

FILED: September 4, 2009

EUGENE ADAMS
Principal Deputy Attorney General for
the District of Columbia

GEORGE C. VALENTINE
Deputy Attorney General
Civil Litigation Division

/s/ Ellen A. Efros
ELLEN A. EFROS [250746]
Chief, Equity I
Telephone: (202) 442-9886
ellen.efros@dc.gov

/s/ Grace Graham
Grace Graham [472878]
Assistant Attorney General
Telephone (202) 442-9784
Facsimile (202) 727-3625
grace.graham@dc.gov

/s/ Sarah Sulkowski
SARAH SULKOWSKI [493235]
Assistant Attorney General
441 Fourth Street N.W., Suite 600 South
Washington, D.C. 20001
Telephone (202) 724-6627
Facsimile (202) 730-1454
sarah.sulkowski@dc.gov

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Defendants (hereinafter "the District"), pursuant to Federal Rule of Civil Procedure 60(b)(5), submit this Memorandum in support of the attached Motion to Vacate the December 12, 2003 Consent Order ("Consent Order") and to Dismiss Action. The District has remedied the statutory violation that gave rise to the Consent Order, and there is thus no basis for continuation of this Court's jurisdiction. This fact, standing alone, supports dismissal of this action.

Further, the remediation of the original systemic violations, as well as the current economic and fiscal conditions faced by the District, are the very type of "changed circumstances" recognized by the Supreme Court in *Horne v. Flores*, 129 S. Ct. 2579, 2593 (2009), that make continued enforcement of a consent decree inequitable. Thus, these changed circumstances also provide an independent ground for dismissal of this action.

Moreover, a separate and independent ground exists for vacatur of the Consent Order, in that the District is in substantial compliance with the exit criteria established by the Court. Accordingly, continued federal judicial oversight is no longer either equitable or permissible.

I. INTRODUCTION

The Supreme Court has long recognized, and most recently reemphasized in *Horne*, that the only legitimate goal of a consent order is to secure compliance with the law. Any specific obligation imposed by such an order is, then, simply a means to the same end—statutory compliance. Extra-statutory requirements unduly interfere with local autonomy and with the separation of powers, implicating serious federalism

concerns. Such orders also impose considerable legal and administrative burdens on local government and its taxpayers.

As discussed *infra*, the District is now in compliance with the Ervin Act, 21 D.C. CODE §§ 501 *et seq.*, and the Consent Order therefore should be dissolved. Simply put, this litigation can continue only if the Court continues to impose requirements beyond those mandated by law, a violation of *Horne*. Moreover, it is plainly erroneous to give continued effect to the Consent Order given the significantly changed circumstances—namely, the complete transformation of the District's mental health system that has occurred in the past decade, in compliance with state law. In short, there is no ongoing violation of law that could support this Court's jurisdiction, and continued enforcement of the consent decree would be inequitable under the circumstances of this case.

Moreover, the Consent Order should be vacated according to its own terms, because the District has demonstrated substantial compliance with the exit criteria established by the Court, and it is therefore in the interests of justice that the case be dismissed.

In the alternative, the Court should at the very least modify the Consent Order, and all other orders currently in effect, to eliminate any provisions that are not reasonable and necessary to remedy a current and ongoing violation of the Ervin Act.

II. PROCEDURAL BACKGROUND

In this class action litigation, which commenced on May 31, 1974, Plaintiffs alleged both constitutional and statutory violations based on the District's historical failure to relocate inpatients from Saint Elizabeths to alternative facilities where they could benefit from treatment in less restrictive environments. On February 7, 1975, the

Court certified a Plaintiff class consisting of "all persons who are now or who may be hospitalized in a public hospital pursuant to 21 D.C. Code § 501 *et seq*. [the Ervin Act], and who need outplacement from that public hospital, as presently constituted, into alternative care facilities, such as nursing homes, foster homes, personal care homes and half-way houses, in order to receive suitable care and treatment in the least restrictive setting possible." (Feb. 7, 1975 Order Granting Class Certification ("Class Cert. Order") at 1.)

On December 23, 1975, the Court concluded that the case could be resolved on statutory grounds alone and found that the District was in violation of the Ervin Act. Specifically, the Court found that the District had failed to ensure that civilly committed mentally ill individuals were afforded care and treatment in the least restrictive environment consistent with their needs and those of the public. *Dixon v. Weinberger*, 405 F. Supp. 974, 977-79 (D.D.C. 1975) ("*Dixon* Decree").

The Court based its finding, in large part, on the approximately 43% of inpatients at Saint Elizabeths who required care and treatment in alternative facilities, including nursing homes, personal care homes, foster homes, and halfway houses. *Id*. at 976. The Court ordered the District to present a plan detailing how the District would meet its duty to provide these individuals, and those similarly situated, with alternatives to inpatient treatment. *Id.* at 980.

Over the next 20 years, this Court entered multiple consent orders setting forth specific plans and requirements that the District agreed to implement, including the 1980 Consent Order setting a target compliance date of December 31, 1985,[1] and the 1992

[1] Congress subsequently postponed the compliance deadline to October 1, 1991, as part of the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, Pub. L. No. 98-621, 98 Stat.

Service Development Plan ("SDP") setting deadlines for the provision of particular services to specific groups. (*See* Apr. 30, 1980 Consent Order at 2; Jan. 27, 1992 Order Approving Parties' Agreement.) The Court subsequently appointed a special master to monitor the District's efforts to comply with the SDP. *See Dixon v. Kelly*, No. 74-285, 1993 U.S. Dist. LEXIS 6511, at *8 (D.D.C. May 14, 1993).

In 1997, finding that the District still had not achieved compliance with the SDP, the Court granted Plaintiffs' motion for the appointment of a receiver. *See Dixon v. Barry*, 967 F. Supp. 535 (D.D.C. 1997) ("*Dixon II*"). On March 6, 2000, finding that the District was "committed to operating [its] mental health system in compliance with the Court's orders," the Court entered a consent order converting the receivership to a transitional receivership and providing that "the day-to-day operations of the mental health system

. . . be returned to the District of Columbia government" no later than April 1, 2001. (March 6, 2000 Consent Order at 1.) In the March 6, 2000 Order, the Court appointed a transitional receiver, Dennis R. Jones, who was empowered to "develop, in consultation with the parties, a cost-effective plan designed to implement the orders and decrees in this case." (*Id.* at 1.)

Mr. Jones submitted his proposed plan in March 2001, and the Court approved it the following month. (*See* March 28, 2001 Final Court-Ordered Plan ("Final Court-Ordered Plan").) The Final Court-Ordered Plan provides a broad framework of goals intended to create an "integrated, comprehensive and cost-effective community-based plan for the provision of mental health care in the District." (*Id.* at 2.)

3369, *codified at* 24 U.S.C. §§ 225 *et seq.* (transferring authority over Saint Elizabeths Hospital from the federal government to the District government).

In May 2002, the Court terminated the transitional receivership and appointed Mr. Jones as court monitor, vesting him with responsibility for monitoring the District's compliance with the Final Court-Ordered Plan. (*See* May 23, 2002 Consent Order Terminating and Vacating Receivership.) In 2003, the parties agreed to an order establishing nineteen (19) exit criteria and providing for dismissal of this litigation once the District had substantially complied with each criterion. (*See* December 12, 2003 Consent Order at 2.)

To date, the court monitor has filed fourteen (14) monitoring reports (not including supplemental reports) with the Court, addressing the District's progress with respect to both the Final Court-Ordered Plan and the exit criteria. Six exit criteria have been moved to inactive status, and the court monitor recently found notable progress with regard to another six criteria. In short, the court monitor's reports support the District's position that it has established a broad range of community treatment alternatives sufficient to ameliorate the original statutory violation and substantially comply with the remaining exit criteria.

III. LEGAL STANDARD

As the Supreme Court recently re-emphasized in *Horne*, the "critical question" that a district court must answer under Rule 60(b)(5) is whether the movant has satisfied the objective of a court order—that is, whether the movant has remedied the underlying violation of law. *Horne*, 129 S. Ct. at 2595; *see also Bd. of Educ. of Okla. Pub. Schs. v. Dowell*, 498 U.S. 237, 247 (1991) ("In the present case, a finding by District Court that [the agency] was being operated in compliance with the commands of the [law] and that

it was unlikely the [agency] would return to its former ways, would be a finding that the purposes of the . . . litigation have been fully achieved.").

In *Horne*, several English-Language Learner ("ELL") students and their parents filed a class action alleging that an Arizona school district was violating the Equal Educational Opportunities Act of 1974 ("EEOA") by providing inadequate ELL instruction.[2] 129 S. Ct. at 2588. The district court entered a declaratory judgment in favor of the plaintiffs, finding that the state's funding for the special needs of ELL students was arbitrary and not related to the actual funding needed to cover the costs of ELL instruction. *Id.* at 2589. It therefore ordered that the State appropriately fund its ELL programs. *Id.*

A few years later, state officials moved for relief from the order pursuant to Rule 60(b)(5), on the ground of changed circumstances. *Id.* at 2591. The district court denied the motion, and the Court of Appeals affirmed. *Id.*

The Supreme Court reversed, holding that both of the lower courts had erred in focusing on whether the state was complying with the district court order, instead of asking whether the state "is now fulfilling its statutory obligation by new means." *Id.* at 2589. In reaching this conclusion, the *Horne* Court began with the fundamentals of Rule 60(b)(5). The Rule permits a party to obtain relief from a judgment or order "if, among other things, 'applying [the judgment or order] prospectively is no longer equitable.'" *Id.* at 2597 (quoting FED. R. CIV. P. 60(b)(5)). Thus, Rule 60(b)(5) "provides a means by which a party can ask a court to modify or vacate the judgment or order if 'a significant

[2] The EEOA requires a state to "take appropriate action to overcome language barriers that impede equal participation by its students in its instructional programs." *Horne*, 129 S. Ct. at 2589 (internal quotation marks omitted).

change either in factual conditions or in law' renders continued enforcement 'detrimental to the public interest.'" *Id.* at 2596-97 (quoting *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 384 (1992)).

The *Horne* Court emphasized that "Rule 60(b)(5) serves a particularly important function in . . . institutional reform litigation." *Id.* at 2593 (citing *Rufo*, 502 U.S. at 380). "For one thing, injunctions issued in such cases often remain in force for many years, and the passage of time frequently brings about changed circumstances—changes . . . in governing law . . . and new policy insights—that warrant reexamination of the original judgment." *Id.* "Second, institutional reform injunctions often raise sensitive federalism concerns," particularly where they involve "areas of core state responsibility" or "ha[ve] the effect of dictating state or local budget priorities." *Id.* Moreover, consent decrees often "go well beyond what is required" by law, and thereby improperly deprive successor officials of their "'designated legislative and executive powers.'" *Id.* at 2594 (quoting *Frew v. Hawkins*, 540 U.S. 431, 441 (2004)). When "state and local officials . . . inherit overbroad or outdated consent decrees that limit their ability to respond to the priorities and concerns of their constituents, they are constrained in their ability to fulfill their duties as democratically-elected officials." *Id.* (internal quotation marks omitted).

In recognition of these features of institutional reform decrees, *Horne* reiterated that "courts must take a 'flexible approach' to Rule 60(b)(5) motions addressing such decrees." *Id.* (quoting *Rufo*, 502 U.S. at 381); *see also Frew*, 540 U.S. at 441; *NLRB v. Harris Teeter Supermarkets*, 215 F.2d 32, 35 (D.C. Cir. 2000); *United States v. W. Electric Co.*, 46 F.2d 1198, 1202-03 (D.C. Cir. 1995) (noting the Supreme Court's recognition in *Rufo* that "it should generally be easier to modify an injunction in an

institutional reform case than in other kinds of cases"). In applying this flexible approach, "courts must remain attentive to the fact that 'federal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate [federal law] or does not flow from such a violation.'" *Horne*, 129 S. Ct. at 2595 (quoting *Milliken v. Bradley*, 433 U.S. 267, 282 (1977)). "When the objects of the decree have been attained—namely, when [statutory] compliance has been achieved—responsibility for discharging the State's obligations must be returned promptly to the State and its officials." *Id.* at 2596 (quoting *Frew*, 540 U.S. at 442) (internal quotation marks and brackets omitted).

These fundamental principles were not followed by the lower courts in *Horne*, which erred by failing to recognize that an institutional reform decree must end as soon as the underlying statutory violation is remedied. "Rather than applying a flexible standard that seeks to return control to state and local officials as soon as a violation of federal law has been remedied . . . , the Court of Appeals concerned itself only with determining whether [the defendants' actions] complied with the original declaratory judgment order." *Id.* at 2595. This was error. *Id.* "[R]elief may be warranted even if [defendants'] actions have not 'satisfied' the original order," *id.* at 2597 (citing FED. R. CIV. P. 60(b)(5)); that is, institutional reform litigants may instead obtain relief "if prospective enforcement of that order is no longer equitable." *Id.* To make such a determination, a court "need[s] to ascertain whether ongoing enforcement of the original order was supported by ongoing violation of [] law." *Id.* (quoting *Milliken*, 433 U.S. at 282). If the State is "no longer in violation of [the statute] . . . , [then] continued

enforcement of the District Court's original order is inequitable within the meaning of Rule 60(b)(5), and relief is warranted." *Id.* at 2606.

It is against these decisional precedents that the instant motion must be evaluated. Applying *Horne's* directives, this Court should find that the District has remedied the lack of community-based treatment alternatives identified in the *Dixon* Decree, and that changed circumstances—including undisputed major structural and other improvements to the Department of Mental Health ("DMH") and to the delivery of public mental health services in the District—have negated any justification for federal court oversight of this local function. In other words, because a "durable remedy has been implemented, continued enforcement of the order is not only unnecessary, but improper." *Id.* at 2595 (emphasis added) (citing *Milliken*, 433 U.S. at 282).

IV. THIS COURT SHOULD VACATE THE CONSENT ORDER AND DISMISS THE CASE BECAUSE THE DISTRICT HAS PROVIDED A DURABLE REMEDY TO THE STATUTORY VIOLATION UNDERLYING THE *DIXON* DECREE.

A. The District Has Remedied the Statutory Violation Giving Rise to the 1975 *Dixon* Decree.

In 1975, this Court held that the District had violated the Ervin Act by "failing to place plaintiffs and members of their class [in] . . . less restrictive alternatives to [Saint Elizabeths]." *Dixon* Decree, 405 F. Supp. at 979 (citing 21 D.C. CODE §§ 501 *et seq*.).[3] The Court's holding was based on the determination by Saint Elizabeths' own staff that 43% of inpatients—thousands of individuals—required care and treatment in alternative,

[3] As the U.S. Court of Appeals for the D.C. Circuit has explained, the Ervin Act's least-restrictive-alternative requirement is merely a legislative articulation of a fundamental principle "inher[ent] in the very nature of [all] civil commitment, which entails an extraordinary deprivation of liberty justifiable only when the respondent is mentally ill to the extent that he is likely to injure himself or other persons if allowed to remain at liberty." *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969) (internal quotation marks omitted).

less restrictive facilities, but nevertheless remained institutionalized due to the lack of available community-based services. *Id.* at 976. The linchpin of the Court's decision, then, and the particular harm the Court sought to remedy, was unnecessary institutionalization. *See id.* at 975. The Court therefore ordered the District to submit a remedial plan addressing the number of inpatients who required alternative placements and offering tentative solutions to the lack of alternative placement options. *Id*.

The District's radical restructuring of its mental health service delivery system has since corrected the statutory violations found by the Court in 1975. Indeed, on facts almost identical to those of this case, a plurality of the Supreme Court held that a local government had satisfied the analogous least-restrictive-environment requirement of the Americans With Disabilities Act ("ADA"). *Olmstead v. L.C.,* 527 U.S. 581, 592 (1999) (citing 28 CFR pt. 35, App. 1, p. 450 (1998))

The ADA's deinstitutionalization mandate, like that of the Ervin Act, is intended to prevent precisely the type of harm that the *Dixon* Plaintiffs alleged at the outset of this case in 1974: namely, unnecessary confinement in a state-run hospital. *Id.* In *Olmstead* (as here), the original statutory violation arose from the state's continued institutionalization of mentally ill individuals long after their treatment professionals recommended their transfer to community-based care. *See id.* at 593, 607. Under these circumstances, the Supreme Court plurality held that the state could meet the ADA's least-restrictive-treatment requirement by "demonstrat[ing] . . . a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less-restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." *Id.* at 605-06.

Olmstead, then, stands for a core principle that is as applicable to the Ervin Act as it is to the ADA—that the state can comply with a law requiring it to provide mental health treatment in the least restrictive environment by creating a system that provides of a range of community-based mental health services and supports, and a discharge plan that moves patients into community treatment at a reasonable pace. These are the principal elements that were found lacking by the *Dixon* Court in 1975. As evidenced by the range of currently available community-based alternatives more fully delineated below, these elements are indisputably present today, a wholesale change in circumstances that compels the dismissal of this litigation.

1. The District currently provides a broad range of community-based services and supports.

The District's mental health system today bears little resemblance to the one that existed when this case began more than three decades ago. In 1974, Saint Elizabeths was the epicenter of the District's mental health system, where over 3,600 mental health consumers in the District were treated. (*See* Complaint ¶ 1.) There were few, if any, alternatives to institutionalization at that time.

During the intervening years, however, through the concerted efforts of policy-makers under the guidance and supervision of the Court, the District undertook the massive shift in policy and practice mandated by the *Dixon* Decree—from a system in which individuals were housed and treated in the massive institutional setting of Saint Elizabeths to a system that provides a range of least restrictive, community-based alternatives. That systemic change is now complete.

As envisioned in the Final Court-Ordered Plan, Saint Elizabeths has been transformed from primarily a custodial or secondary care facility to one providing tertiary

care.[4] Hospitalizations have decreased 77% since 2003. (Declaration of Stephen Baron ("Baron Decl."), attached at Exhibit 1, ¶ 7 (noting decrease in number of hospitalizations from 1800 to 400).) As of August 9, 2009, only 217 Ervin Act consumers[5] were being treated in the Hospital; approximately 12,000 mental health consumers, then, are treated in the community. (*Id.* ¶¶ 4, 6.)

The District has achieved this accomplishment in part by expanding the system's capacity to refer acute psychiatric emergencies to local hospitals that can obtain Medicaid reimbursement and provide better-integrated healthcare with shorter stays. (*See* Final Court-Ordered Plan at 23 ("Acute care hospital inpatient psychiatric admissions will very likely be less stigmatizing, and more likely to result in integrated healthcare and shorter lengths of stay (based on nationwide statistics) than emergency admissions to Saint Elizabeths have been."); *see also* Baron Decl. ¶ 7.) As a result of agreements with United Medical Center and Providence hospitals, for example, the court monitor found that "[o]nly one admission to [Saint Elizabeths] in a recent 4-month period occurred because of the lack of an acute care bed in the community." (July 2009 Court Monitor Report at 3.) The court monitor applauded the District's effort and concluded that "[]DMH is for the first time operating as intended under the Court-ordered plan." (*Id.*)

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[4] Tertiary Care is defined as highly specialized medical care, usually provided over an extended period of time, involving advanced and complex procedures and treatments performed by medical specialists in specialized facilities. Secondary Care, or acute care, is defined as medical care provided by a specialist or facility upon referral by a primary care physician or emergency room. Tertiary Care, or custodial care, as used here, is defined as care primarily provided in a hospital setting even though the individual is eligible to be treated in the community. (Baron Decl. ¶ 32.) As the Court noted in the *Dixon* Decree, in 1975, 43% of inpatients at the Hospital could have been treated in community-based settings.

[5] An additional 153 patients currently treated at the Hospital are there as a result of criminal case court orders and either have been found Not Guilty by Reason of Insanity, are subject to the Miller Act as sexual psychopaths, or have been found competent to stand trial and are awaiting trial. (Baron Decl. ¶ 6.) These individuals, because they are not hospitalized pursuant to the Ervin Act, are not class members.

This dramatic drop in hospitalizations is also the result of a corresponding increase in community-based services and supports, which provide treatment in the least restrictive environment, by DMH and twenty-eight (28) private Core Service Agencies ("CSAs").[6] This Court's initial finding in 1975 required treatment in the least restrictive environment and compelled community-based alternatives including nursing homes, foster homes, personal care homes, and half-way houses. *See Dixon* Decree, 405 F. Supp. at 979; *accord Lake v. Cameron*, 364 F.2d 657, 659 (D.C. Cir. 1966). The District, however, has instituted mental health supports and services extending beyond group homes to supported housing, supported employment, and crisis stabilization, as well as other services provided through the community-based Mental Health Rehabilitative Services ("MHRS") system. (*See* Final Court-Ordered Plan at 31, 33 (requiring that the District give "high priority" to developing programs for supported housing, supported employment, and crisis stabilization, and noting that the development of MHRS, the Medicaid Rehabilitation Option, was "critical to providing a solid foundation for the new system").)

The District's efforts have been so successful that, as identified above, the vast majority of adult mental health consumers in the District are now treated in the community. Where, as here, an astonishing 98% of consumers receive a range of community-based supports and services (Baron Decl. ¶ 4), there is no question that the

[6] The District's development of the Core Service Agency network was another key goal of the Final Court-Ordered Plan. (*See* Final Court-Ordered Plan at 14 (goal is to establish provider "home" to be referred to as a "Core Service Agency").) The CSA is defined as a "community-based provider" of mental health services and mental health supports that is certified by DMH and that acts as a "clinical home for consumers of mental health services by providing a single point of access and accountability for diagnostic assessment, medication-somatic treatment, counseling and psychotherapy, community support services, and access to other needed services." D.C. CODE § 7-1131.02(3).

District has satisfied the *Olmstead* standard and is now in compliance with the Ervin Act.[7]

A few examples, set forth below, illustrate the District's comprehensive and effective reform of its mental health system.

a. Mental Health Rehabilitative Services ("MHRS")

The comprehensive system of community-based services required by the *Dixon* Decree could not have been developed without critical resources provided by the federal government through Medicaid. Consistent with the Final Court-Ordered Plan, the District amended its Medicaid State Plan in 2002 to become eligible for federal reimbursement (70% matching funds) for a variety of mental health services delivered in the community. The MHRS system provides federal funding for services such as diagnostic assessment, medication and somatic treatment, counseling, community support, and Assertive Community Treatment ("ACT"). *See* 22A DCMR § 3402; *see also* Baron Decl. ¶ 9. With the advent of the MHRS system, the District has now fully implemented what the court monitor has called "the single most significant method of federal reimbursement of community mental health services." (*See* Final Court-Ordered Plan at 9.)

For example, ACT is specifically geared toward providing care *outside an office setting*[8] to the treatment-resistant consumers who are at greatest risk for re-hospitalization. *See* 22A DCMR § 3399.[9] As one of only seven states (7) to support

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[7] References to the Ervin Act refer to the specific violation found by the Court in the *Dixon* Decree.

[8] Under ACT, at least 60% of services must be provided outside an office setting. *See* 22A DCMR § 3410.20.

[9] Specifically, ACT is an "evidenced-based practice model that provides a proactive, consumer driven, intensive, integrated rehabilitative, crisis, treatment, and mental health rehabilitative community

state-wide ACT programs, the District is well ahead of the curve in demonstrating its commitment to treatment of the mentally ill in the least restrictive environment.[10] And DMH has recently raised ACT reimbursement rates from $26.58 per unit to $33.23 per unit, a 25% increase, in an effort to further increase utilization of ACT services. *See* 29 DCMR § 5213.1. These initiatives are yielding results: since March 31, 2008 alone, the number of enrolled ACT consumers has increased from 351 to 523, and several new ACT teams are ready to accept new referrals, raising total capacity to 700.[11] (July 2009 Court Monitor Report at 31-32; *see also* Baron Decl. ¶ 11 (noting increase to 535 as of June 1, and capacity at 700).) As the court monitor recently reported, "Clearly ACT is now being utilized as the appropriate service for persons with the highest service needs." (July 2009 Court Monitor Report at 32.)

In short, establishing a steady federal funding stream for ACT and other services has been crucial to ensuring their availability in the community and, thus, to meeting the Ervin Act's requirement of avoiding unnecessary hospitalizations. *See Dixon* Decree, 405 F. Supp. at 979.

b. Community-Based Housing

The need for community-based housing is self-evident; a mental health system dedicated to community-based treatment should provide various supported living options

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support service to adult consumers with serious and persistent mental illness. Services are provided by an interdisciplinary team, with dedicated staff time and specific staff to consumer ratios in order to assist consumers to meet their goals in the community and assist with integration into the community. *ACT is a specialty service*." 22A DCMR § 3399 (emphasis added).

[10] *See* National Alliance on Mental Illness ("NAMI"), *Pact: Program of Assertive Community Treatment*, available at http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=49870 (accessed September 4, 2009).

[11] Community Connections and Green Door have been certified as ACT providers within the past six months, and Anchor Mental Health has submitted an application for certification as an ACT provider. (*See generally* July 2009 Court Monitor Report at 31.)

in order to reduce unnecessary hospitalizations. In an informal survey conducted through the National Association of State Mental Health Program Directors ("NASMHPD") and through discussions with other state directors of mental health programs, DMH Director Baron believes that the District provides more community-based housing for the mentally ill per capita than do the majority of states, and is in the top 20% of the nation in providing affordable housing. (Baron Decl. ¶ 16.)

Comparisons aside, the District has made a tremendous investment in community-based housing for mental health consumers. For consumers who need 24-hour supervision and support, DMH provides funding to support 217 consumers in contracted Mental Health Community Residence Facilities ("MHCRFs") and 378 consumers in independent MHCRFs, which are licensed and monitored pursuant to regulations. (*Id.* ¶ 13.)

For those who do not need 24-hour supervision, DMH has 461 units for Supported Independent Living ("SIL"). (*Id.* ¶ 14.) SIL provides a safe home setting that includes community support within a consumer's living environment, which fosters recovery from mental illness while allowing the individual to live independently. (*Id.*) Services include training in life skill activities, home management, community services, and additional supports as needed. (*Id.*) The CSA also conducts weekly home visits and monitoring. (*Id.*)

In addition, under the locally funded "Home First Subsidy Program," which is unique in the metropolitan area, the District spends between $5.5 and $6 million per year to subsidize an additional 750 mentally ill consumers, primarily for independent supported housing. (*Id.* ¶ 15.) Neither Maryland nor Virginia provides such a locally

funded subsidy for mental health consumers to obtain permanent supported housing. (*Id*.)

In November 2008, the District made another substantial investment in community-based housing by allocating an additional $14 million to construct, renovate, or rehabilitate affordable housing for persons with mental illness, for a total of 300 housing units. (*Id.*) Currently, 239 units are under construction, renovation or contract, and the first 40 have already been filled. (*Id*.)

As of June 30, 2009, as a result of the remedies that the District has implemented concerning the original violation of the Ervin Act, DMH provided these community-based housing options to over 2000 consumers, many of whom would no doubt be housed and treated in the Hospital absent the District's intensive efforts. (*See id.* ¶ 12.)

c. Supported Employment

Supported employment is specifically identified in the Final Court-Ordered Plan as a "high priority." (Final Court-Ordered Plan at 33.) The District began its evidence-based supported employment program in 2003. (Baron Decl. ¶ 17.) Today, the District operates a successful supported employment program that leads to sustained community integration for many mental health consumers.

The District works quickly to place individuals appropriately; indeed, 90.4% of consumers are served within 120 days of referral.[12] (*See* July 2009 Court Monitor Report at 9.) As of June 1, 2009, a total of 512 consumers were enrolled in the supported employment program, an increase of 245% since fiscal year 2004. (*See* July 2009 Court Monitor Report at 30; Baron Decl. ¶ 20 (noting increase from 209 to 512).) The

[12] As discussed *infra* in the Appendix, this exceeds the numerical target in exit criterion 10 by more than 20 percentage points.

program's capacity to serve consumers will increase to 660 by the end of FY 2010 and to 700 by FY 2011. (Baron Decl. ¶ 18.) More than 30 consumers have now "graduated" from the program entirely, in that they have maintained steady employment for more than a year and require no further active services from the supported employment program. (*Id.* ¶ 19.)

The District's supported employment plan thus goes well beyond the *Dixon* Decree's requirement to provide "nursing homes, foster homes, personal care homes, and half-way houses." 405 F. Supp. at 979. Rather, the District provides options for mentally ill individuals to fully rejoin their communities as productive and independent residents.

d. Crisis Services

Crisis Services are essential for supporting community-based alternatives to institutionalization, as they allow the system to quickly identify and address issues such as developmental disorders, abuse, trauma, and medical and legal problems, and thereby "return [consumers] to routine functioning as quickly as possible." (Final Court-Ordered Plan at 16.) In 1974, mentally ill consumers seeking treatment for such crises were almost always admitted to Saint Elizabeths. In contrast, the court monitor recently concluded that "DMH has not only developed a comprehensive [crisis services] plan but has consistently followed through to make sure it is implemented." (July 2009 Court Monitor Report at 55; *see also* January 2009 Court Monitor Report at 2 ("[]DMH should be commended for its leadership in developing and implementing a comprehensive approach to crisis/emergency services.").)

DMH's Comprehensive Psychiatric Emergency Program ("CPEP") is the District's entry point for psychiatric detentions and evaluations. For those individuals

who may not need immediate hospitalization, CPEP now includes eight 72-hour extended observation beds, which provide additional flexibility to stabilize psychiatric emergency patients outside the Hospital. (July 2009 Court Monitor Report at 55; *see also* (Declaration of Cynthia Holloway ("Holloway Decl.") ¶ 4, attached at Exhibit 2.) Between October 2007 and June 2009, CPEP served over 6,000 consumers. (Holloway Decl. ¶ 6.) The majority of patients (almost 4,000) were stabilized and discharged directly to the community without further hospitalization, usually to self-care, but sometimes in conjunction with other services such as supported housing or substance abuse programs. (*Id.*) Without CPEP or other crisis services, these patients risked hospitalization at Saint Elizabeths. (*Id.*)

As part of its overall Crisis/Emergency Services plan, DMH also funds 15 crisis/respite beds that are maintained by two private providers: Crossing Place and Jordan House. (*See* January 2009 Court Monitor Report at 18; Holloway Decl. ¶ 7.) These beds are critical because they provide an alternative for voluntary patients who do not need hospitalization but are not quite ready to be returned to their own homes in the community. (Holloway Decl. ¶ 7.) A consumer may use a crisis bed for up to fourteen (14) days at a time, with extensions possible when needed. (*Id.*)

For the first nine months of fiscal year 2008, 114 consumers were sent from CPEP to the crisis beds. (Holloway Decl. ¶ 7.) Since October 1, 2008, 375 consumers have been referred to the crisis beds from hospitals, CSAs, and families or consumers themselves, allowing these consumers to remain in the community for their short-term oversight and care or to be discharged earlier from the hospital. (*See* Baron Decl. ¶ 27.)

To further respond to psychiatric emergencies and avoid unnecessary hospitalizations, DMH fully implemented an adult Mobile Crisis Service ("MCS") in November 2008, which operates from CPEP and is staffed by 18 multi-disciplinary team members, including social workers, mental health counselors, and addiction treatment specialists. (*See* July 2009 Court Monitor Report at 55; Holloway Decl. ¶ 8.) MCS was the product of a year-long collaborative work group consisting of DMH, Metropolitan Police Department ("MPD") representatives, Fire and Emergency Services (FEMS) representatives, consumers, advocates, providers, and court representatives. (Baron Decl. ¶ 28.) MCS is designed not only to respond to emergency calls but also to provide counseling, assessments, transportation assistance, follow-up referrals, and outreach. (Holloway Decl. ¶ 8.)

As of November 2008, when MCS began operations, it has served an average of 170 different individuals a month *in the community*.[13] (*Id.* ¶ 8.) Notably, more than 70% of the consumers experiencing a crisis were maintained in the community, without having to be transferred to CPEP, let alone hospitalized. (*Id*.) The creation and utilization of the MCS demonstrates the District's good faith compliance with the Final Court-Ordered Plan goal of creating a community-based crisis response system through community and inter-agency cooperation. More importantly for purposes of this Motion, it demonstrates adherence to a program of maximizing community-based

[13] While the District maintains that children are no longer included in the class, *see* discussion, *infra*, at 40-41, the District also notes that it has contracted with Catholic Charities to provide mobile crisis services to children under the Child and Adolescent Mobile Psychiatric Service (ChAMPS). (*See* January 2009 Court Monitor Report at 15.) Indeed, from October 2008 to June 30, 2009, ChAMPS has received more than 500 calls; every quarter the percentage of children requiring hospitalization following a call has decreased, from 25% the first quarter of operations (October – December 2008) to 11% in the second quarter and 5% in the third quarter of operations (April – June 2009). (Baron Decl. ¶ 29.)

treatments for consumers in crisis and avoiding unnecessary hospitalizations, as required by the *Dixon* Decree. *See* 405 F. Supp. at 979.

e. Homeless Services

The treatment of homeless consumers merits particular attention in any evaluation of the District's community-based treatment system, because these consumers often lack family and community supports and thus may not seek out services available in the community. For this reason, the homeless face an increased risk of hospitalization or re-hospitalization during mental health emergencies.

As part of its comprehensive strategy, DMH established the Homeless Outreach Program ("HOP") to reach out to homeless consumers by visiting shelters and assisting those in need of mental health services. (*See* July 2009 Court Monitor Report at 33.) From April 1, 2008, through March 31, 2009, the HOP provided services to 1,330 different adults and 185 different children, and had a total of 3,465 face-to-face contacts.[14] (*Id*.)

DMH also provides homeless services through contracts with care providers. For example, since fiscal year 2006 DMH has provided grant funds to the Recovery House at N Street Village, which provides mental health assistance to homeless women. (Baron Decl. ¶ 25.) And in fiscal year 2008, DMH awarded a contract to the Hermano Pedro program, also one of the Catholic Charities, to increase the number of services available to homeless individuals. (*Id*.)

[14] Indeed, the District has already satisfied, by a large margin, exit criteria 13 and 16 (now inactive), which require DMH to serve 150 homeless adults and 100 homeless children and to adopt a comprehensive strategy. (*See* July 2009 Court Monitor Report at 10.)

In his July 2009 report, the court monitor concluded that the "[]DMH Homeless Services Program continued to provide comprehensive services for persons who are homeless and also have significant mental health problems." (July 2009 Court Monitor Report at 33.) This is a demonstrable and compelling sign of a mature mental health delivery system, one that fully complies with the Ervin Act.

f. Conclusion

There is simply no dispute that the District offers a comprehensive range of community-based alternatives to institutionalization that provide consumers with treatment in the least restrictive environment. This change in circumstances compels a finding that the District has remedied the particular harm found in the *Dixon* Decree—namely, unnecessary hospitalizations—and is now in compliance with the Ervin Act. There is thus no continuing violation of law justifying exercise of this Court's continued oversight.

2. Movement to community-based supports and services occurs at a "reasonable pace."

The District has also satisfied the second prong of the *Olmstead* standard by establishing a system that accomplishes deinstitutionalization at a reasonable pace. The most obvious indicator of the effectiveness of the District's community-based mental health system is, of course, the discharge rate at Saint Elizabeths. In 1974, the District had a minimal outpatient system for providing the care necessary to allow patients discharged from the Hospital to integrate into the community and avoid re-hospitalization. Today, in contrast, Saint Elizabeths discharges an average of 30 Ervin

Act patients—or 16% of its Ervin Act inpatient population—every month.[15] (Declaration of Jana Berhow ("Berhow Decl.") ¶ 8, attached at Exhibit 3.)

Moreover, in the fall of 2008, DMH created the Integrated Care Division ("ICD") to focus exclusively on individuals who are in need of intensive care management. (*See* January 2009 Court Monitor Report at 24; *see also* Berhow Decl. ¶ 4.) The underlying purpose is to enable even those individuals with particularly difficult cases to be discharged to community-based services if at all possible. Currently, the ICD is providing oversight for the care of 244 consumers. (Berhow Decl. ¶ 4.) The District has developed a "barriers to discharge" list identifying those consumers with special needs[16] that may be impeding their discharge from the Hospital. (*See id.*) This list also includes those individuals who have been recommended for outpatient commitment by the Mental Health Commission ("Commission") and therefore need to be discharged within fourteen days of the recommendation, pursuant to the Ervin Act.

Further, ICD manages the Integrated Community Care Project, designed to serve up to 30 patients, some of whom may be included on the "barriers to discharge" list. (Berhow Decl. ¶ 7.) Under a contract with the Washington Hospital Center, consumers receive intensive wrap-around services designed to enable these particular patients to move to less-restrictive facilities. (*Id.*; *see also* July 2009 Court Monitor Report at 51-52.) Without these additional services and supports, these consumers, including the

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[15] The District has further illustrated its commitment to community-based treatment by constructing a state-of-the-art facility with a relatively low number of tertiary care beds. The new Saint Elizabeths, now 95% complete, will support only 292 such beds, with an additional 100 beds for overflow if necessary. (*See* July 2009 Court Monitor Report at 43-44.) While patient needs will always determine the necessity of hospitalization, this structure ensures that the mental health system focuses on moving eligible consumers to community-based treatment if it is consistent with their needs.

[16] Some of the special needs include individuals with a diagnosis of both mental illness and mental retardation, and individuals with significant physical disabilities. (*See generally* July 2009 Court Monitor Report at 51-52.)

medically infirm and those with mental retardation, would otherwise either remain at the Hospital or face "very tenuous community placement[s]." (*See* July 2009 Court Monitor Report at 51.) To date, the Washington Hospital Center has enrolled nineteen (19) consumers under the contract, and one has already been discharged from Saint Elizabeths; it plans to accept four more consumers by September 30, 2009. (Berhow Decl. ¶ 7.) The court monitor recently stated that he is "very pleased with the role and beginning efforts of the ICD" and that the District's "focus on this highest risk population should help to not only reduce the census at [the Hospital] but provide greater assurances of successful community tenure." (July 2009 Court Monitor Report at 52.)

Federal courts have held that the *Olmstead* standard is satisfied on facts like these. *See Williams v. Wasserman*, 164 F. Supp. 2d 591, 633-34 (D. Md. 2001) (state provided least restrictive environment by "gradually closing institutions and expanding the number and range of community-based treatment programs," as illustrated by "dramatic" decline in population of state mental hospitals from 7,114 in 1970 to 1,200 in 1997); *Shepardson v. Stephen*, Civil No. 99-CV-558-SM, 2006 U.S. Dist. LEXIS 71775, at *5-*15 (D.N.H. Sept. 29, 2006) (state's participation in Medicaid waiver program was sufficient to satisfy integration requirement despite waiting list because, "[a]lthough more can always be done, the reality is that states must make difficult decisions when allocating necessarily limited resources," and "defendants ha[d] proven that they maintain[ed] a comprehensive and effective working plan for placing qualified persons . . . in less restrictive settings").

In sum, there simply is no question that the District has succeeded in implementing an effective plan for complying with the Ervin Act by moving consumers to appropriate, less restrictive environments at a "reasonable pace." *See Olmstead*, 527

U.S. at 606. In the original *Dixon* Decree, almost half of the inpatients at the Hospital required care and treatment in alternative facilities. 405 F. Supp. at 976 (referencing 43% of inpatients). Where, as here, the discharge rate is 16% of Ervin Act consumers per month (with a total census of only 370), it is indisputable that the District has, consistent with the Ervin Act, established a mental health delivery system that appropriately limits the unnecessary hospitalization of class members.

Therefore, under *Horne*, the Consent Order should be vacated and this case should be dismissed.

B. The Remedy Implemented By The District Is Durable.

Under *Horne*, "[i]f a durable remedy has been implemented, continued enforcement of the order is not only unnecessary, but improper." 129 S. Ct. at 2595 (citing *Milliken*, 433 U.S. at 282); *see also Philadelphia Welfare Rights Org. v. Shapp*, 602 F.2d 114, 1120 (3d Cir. 1979) (distinguishing between complex ongoing remedial decrees and simple prohibitory injunctions (*e.g.*, injunction to close a prison unit) that, if vacated, would leave class open to the evils to which the lawsuit was first addressed). As discussed below, the District has implemented permanent structural changes and will remain subject to a strong external oversight structure by the Office of Inspector General and Office of the D.C. Auditor. Accordingly, under *Horne*, this case should be dismissed.

1. The District has instituted structural changes supporting continued deinstitutionalization.

In 2001, the District cemented its commitment to providing community-based treatment by creating DMH as a cabinet-level department with the express purpose of developing a system of care that ensures treatment in the "most integrated setting that can

be accommodated." D.C. CODE § 7-1131.03 (d)(3). In compliance with the Final Court-Ordered Plan, DMH has independent contracting and procurement authority and personnel authority. *See id.* § 7-1331.04(14-15); *see also* Final Court-Ordered Plan at 32-33 (requiring creation of new department with the necessary authority to meet the needs of the District's residents). Furthermore, the District has demonstrated its ability to attract and retain qualified leadership. Indeed, for the last 3 ½ years, DMH has had the "high-quality, stable leadership" of Director Stephen Baron. (*See* July 2008 Court Monitor Report at 4 (finding that "DMH leadership appears to be increasingly cohesive and productive under the overall leadership of Mr. Steve Baron").)

Moreover, the District has fulfilled another goal of the Final Court-Ordered Plan by creating "a mental health agency with a meaningful separation between its authority and provider functions, and the unambiguous responsibility and authority, and the necessary resources, to promulgate and sustain clear goals and values for the system." (*See* Final Court-Ordered Plan at 3.) DMH's move to close the DC CSA, as discussed below, furthers this goal by reducing DMH's role as a service provider and increasing its role as the oversight authority for the public mental health system. (*See id.* at 3.)

In short, these structural changes within the District government have created a self-sustaining organization necessary to ensure the long-term viability of a community-based service delivery system.

2. Legislative changes to the Ervin Act provide additional oversight to ensure that consumers are being treated in the least restrictive environment.

The Ervin Act has been substantially modified to further incorporate the "least restrictive environment" mandate into the civil commitment process. Specifically, the

District has amended the Ervin Act to require a review of all civilly-committed patients every 90 days and to specifically evaluate whether each civilly committed consumer requires continued commitment and whether the individual can be treated in a less-restrictive environment. *See* D.C. CODE § 21-546(b)(2) (2002 amendment).

In 2005, the District eliminated indeterminate civil commitments. *See id.* § 21-545 (2005 amendment). All civil commitments are now limited to one year, with an option to file for recommitments for subsequent one-year periods. *Id*. In addition, the District has amended the Ervin Act to specifically require the discharge of any hospitalized patient within 14 days when recommended for outpatient treatment by the Commission. *See* D.C. CODE § 21-526(e). Over 100 consumers have been out-placed from the Hospital since January 2007, in accordance with this provision. (Berhow Decl. ¶ 11.) Moreover, if any member of the plaintiff class were to be restricted to the Hospital after outpatient treatment was warranted, the individual could easily invoke a local remedy to obtain enforcement of this specific provision before the D.C. Superior Court.

These legislative changes, then, provide the legal framework, with required internal checks and balances and readily available remedies, to ensure that consumers receive treatment in the community if at all possible.

3. DMH is discontinuing its role as a direct care provider, shifting its Core Service Agency services to private providers.

Under the Final Court-Ordered Plan, DMH itself was to operate a CSA until sufficient private provider capacity had developed. (*See* Final Court-Ordered Plan at 24.) As the court monitor's reports detail, that process has begun. As of August 24, 2009, DMH has transferred 2,515 of the approximately 3,200 eligible consumers to private providers to date. (Baron Decl. ¶ 10.) On August 1, 2009, the DC CSA ended all

operations, and the Mental Health Authority of DMH under the Office of Programs assumed all remaining programs of the DC CSA, including the treatment of the remaining consumers. (*Id.*) As the court monitor most recently reported, "[]the DC CSA process is moving forward in a positive way." (July 2009 Court Monitor Report at 52.) DMH's performance on such an important and complex initiative further demonstrates the District's ability to operate the agency without continued oversight from the Court.

4. DMH has a vigorous Quality Improvement system.

DMH has established several internal mechanisms to collect and utilize data in order to evaluate the agency's own performance, allowing it to build upon the reforms that have already been instituted. First, the Division of Quality Improvement ("QI") located within the Office of Accountability directs quality improvement efforts agency-wide. (*See* Declaration of Anne Weiss ("Weiss Decl.") ¶ 4, attached at Exhibit 4.) Second, the Internal Quality Committee meets monthly to review and evaluate QI initiatives, and focuses on priority areas including major unusual incidents; mortality reviews; review of the MHSIP survey; review of high-end utilization of community support services; and review of the current treatment plan format. (*See* July 2009 Court Monitor Report at 15; *see also* Weiss Decl. ¶ 5.)

Moreover, DMH has convened an external Quality Council, which meets on a quarterly basis, that includes providers so that all stakeholders—government, providers, consumers, and advocates—have the opportunity to collaborate in QI programs. (*See* July 2009 Court Monitor Report at 15 (noting the priority areas for consideration by the

Council including implementation of web-based LOCUS/CALOCUS application[17] and the new provider "score card"); *see also* Weiss Decl. ¶ 6.)

These structures would not be effective without the collection of a variety of data, which DMH uses to assess and adjust policies where necessary. Mechanisms to collect pertinent data include the Mental Health Statistical Improvement Program ("MHSIP"), an annual consumer service survey. (*See* July 2009 Court Monitor Report at 5 (noting that MHSIP is one of three mechanisms adopted by DMH).) Further, in 2003, DMH also contracted with the Consumer Action Network ("CAN") to conduct convenience sampling and focus-group studies on quality of care. (*Id.*) As the court monitor recently reported, in May 2009 the CAN presented DMH with a summary of focus group findings for the first quarter of calendar year 2009, identifying three priority concerns. (*Id.*) In response, DMH has already "[]begun to formulate responses … identifying the multiple interventions that might effect improvement." (*Id.*)[18]

These examples illustrate the District's ability to continuously evaluate DMH's services and implement changes where necessary, *without* Court supervision.

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[17] LOCUS evaluation (CALOCUS for children) allows a provider to assess a consumer's functioning in a variety of domains; the lower the final score, the more assistance and services the consumer requires.

[18] For example, one of the specific concerns raised by a CAN focus group regarded the continuity of care between physical health and mental health treatment. (*See* Weiss Decl. ¶ 11.) As a result, CSAs are required to review thirty clinical records per quarter to ascertain whether there is appropriate coordination. (*Id.*) DMH's Director of Consumer and Family Affairs has been meeting with the Office of Disability Rights to develop a system for consumer posting of medications and treatment plans online; clinical practice guidelines are being developed by the Office of Programs to address care coordination issues; and DMH is participating in a citywide "Chronic Care Initiative Grant" with two CSAs as the pilot sites in the District. (*Id.*)

5. The D.C. Auditor and Office of Inspector General will continue to provide external oversight.

The District will remain accountable to external independent oversight authorities after this case is dismissed. Local law requires every executive agency to develop a performance plan annually, and plans are audited randomly on a yearly basis by the Office of the D.C. Auditor. *See* D.C. CODE §§ 1-614.14(a), (c) (auditor conducts an audit of selected performance measures of certain agencies each fiscal year). DMH's fiscal year 2008 Performance Accountability Report was selected for audit in the summer of 2009. (Baron Decl. ¶ 30.) The audit examines DMH's performance in areas relevant to *Dixon*, including community-based crisis services and improved Community Service Review scores. (*Id.*) The final report will be issued before the end of 2009, and the information in the forthcoming report will be utilized to evaluate DMH's performance in terms of meeting its own internal goals. (*Id.*)

Additionally, the Office of the Inspector General ("OIG") provides external oversight. The OIG investigates individual cases of alleged patient abuse in addition to the efficiency and effectiveness of DMH programs. *See* D.C. CODE § 2-302.08 (2001).[19] In the past few years, for example, the OIG has audited the DMH School-Based Mental Health Program (November 2008), Provider Reimbursements (November 2007), and DMH's "Implementation of Annual Financial Statement Audit Recommendation for FY 2008" (August 2009). (Baron Decl. ¶ 30.)

Because DMH's performance will remain subject to multiple levels of external review on an ongoing basis, the Court's diligent oversight is no longer warranted.

[19] The Government Accounting Office ("GAO") of the federal government can also review DMH at any time. The last such audit occurred in 2003. (Baron Decl. ¶ 30.)

6. Conclusion

The structural and legislative changes implemented by the District, combined with continuous internal and external quality-improvement processes, represent a substantial change of circumstances and ensure the durability of the District's remedy. The particular harm found by the Court in the *Dixon* Decree—unnecessary hospitalizations—has been ameliorated. *See Dixon* Decree, 405 F. Supp. at 979; *see also Horne*, 129 S. Ct. at 2595. Accordingly, this case should be dismissed.

V. ENFORCEMENT OF THE CONSENT DECREE AND OTHER ORDERS IN THE LITIGATION IS NO LONGER EQUITABLE GIVEN THE CHANGED CIRCUMSTANCES.

A. The Absence of Systemic Legal Violations, Combined With The Implementation of Structural and Legislative Changes, Support Vacatur of the Consent Order and Dismissal of the Litigation.

Absent systemic violations of the Ervin Act, and in light of the major structural and legislative changes identified above, continued enforcement of this sweeping consent decree is inequitable. As the Supreme Court has observed, district courts are empowered to modify or vacate consent decrees based on changed circumstances. *See Horne*, 129 S. Ct. at 2593 ("the party seeking relief bears the burden of establishing that changed circumstances warrant relief, but once a party carries this burden, a court abuses its discretion 'when it refuses to modify an injunction or consent decree in light of such changes'") (citing *Rufo*, 502 U.S. at 383 (quoting *Agostini v. Felton*, 521 U.S. 203, 215, 117 S. Ct. 1997 (1997))). Indeed, judicial experience with institutional reform litigation "has made the ability of a district court to modify a decree in response to changed circumstances all the more important." *Rufo*, 502 U.S. at 393. As the Supreme Court has noted, "injunctions issued in such cases often remain in force for many years, and the

passage of time frequently brings about changed circumstances—changes in the nature of the underlying problem, changes in governing law or its interpretation by the courts, and new policy insights—that warrant reexamination of the original judgment." *Horne*, 129 S. Ct. at 2593; *see also In re Pearson*, 990 F.2d 653, 658 (1st Cir. 1993) ("the district court is not doomed to some Sisyphean fate, bound forever to enforce and interpret a preexisting decree without occasionally pausing to question whether changing circumstances have rendered the decree unnecessary, outmoded, or even harmful to the public interest").

In short, the Supreme Court has determined that consent decrees in institutional reform cases "are not intended to operate in perpetuity" and cannot condemn an agency "to judicial tutelage for the indefinite future." *Dowell*, 498 U.S. at 248-49.

Precisely the same "changed circumstances" recognized by the Supreme Court in *Horne* are present here. There can be no doubt that significant changes to the delivery of mental health services have occurred over the course of this litigation. As described in previous sections, one critical changed circumstance is the District's correction of the systemic violations of the Ervin Act that originally gave rise to the entry of the various orders in this case. In addition, and as also described above, major structural and legislative changes, combined with extensive oversight, constitute another changed circumstance.[20] In summary, DMH today is a completely transformed agency, as is the delivery of mental health services not only to the class, but to all District residents. As such, even if some *de minimis* violation of the Ervin Act remained, a possibility that the

[20] The District also refers the Court to the substantial, good faith compliance exhibited by the District, discussed *infra* at 36-41, that constitutes an additional changed circumstance making continued enforcement of the Consent Decree inequitable.

District rejects, such a violation simply does not rise to the level of the kind of all-encompassing, systemic violation necessary to sustain this Court's continued jurisdiction. The case should be dismissed on this ground alone.

B. Current Economic and Fiscal Conditions Also Support Vacatur of the Consent Order and Dismissal of the Litigation.

In deciding whether to vacate a consent order, it is appropriate for the Court to take into consideration conditions, including economic circumstances, that make compliance substantially more onerous than it originally was. *See Rufo*, 502 U.S. at 393; *Horne*, 129 S. Ct. at 2594 (noting that a consent decree can have the effect to "take funds away from other important programs"). This is especially so where, as here, prior public officials "consent[ed] to, or refrain[ed] from vigorously opposing, decrees that [went] well beyond what is required by [] law." *Horne*, 129 S. Ct. at 2594 (internal citations omitted); *accord Rufo*, 502 U.S. at 393 (officials may "agree to do more than that that which is minimally required by the [law] to settle a case and avoid further litigation[]"). As the Supreme Court noted in *Horne*, to refuse consideration of the District's motion based on a change in conditions is to "bind state and local officials to the policy preferences of their predecessors and thereby 'improperly deprive future officials of their designated legislative and executive powers.'" *Horne*, 129 S. Ct. at 2594 (quoting *Frew*, 540 U.S. at 441).

In this context, the Court has recognized that fiscal problems are relevant to a request for modification or dismissal. "Financial constraints may not be used to justify the creation or perpetuation of [legal] violations, but they are a legitimate concern of government defendants in institutional reform litigation and therefore are appropriately considered in tailoring a consent decree modification." *Rufo*, 502 U.S. at 392-93.

Accordingly, the District's current financial constraints are an appropriate consideration in this case and independently warrant vacatur of the Consent Order.

1. Revenue Gap

In considering this motion, the Court must take into account the publicly documented and indisputably dire current economic climate, and the concomitant financial constraints on the District. Specifically, the District is currently projected to suffer budget shortfalls of $583.5 million (or 10.8% of the total budget) for fiscal year 2009, and $952.2 million (or 16.3% of the total budget) for fiscal year 2010. (Declaration of Merav Bushlin ("Bushlin Decl.") ¶ 4, attached at Exhibit 5.) Under *Horne* and *Rufo*, the Court must consider these severe constraints on the District's ability to continue to absorb the exorbitant legal and administrative expenses associated with court supervision, as outlined below.

2. Payments to the Court Monitor

While the court monitor has provided valuable assistance in terms of aiding the District in accomplishing the objectives outlined in Final Court-Ordered Plan, the Court should note that this assistance is exceedingly expensive and increasingly focused on the day-to-day minutiae of agency operations. Since fiscal year 2003, alone, the District has paid or allocated approximately $3,413,622 for the services of the court monitor. (Baron Decl. ¶ 31.) This does not include the substantial loss of staff time incurred in meeting with the court monitor bi-weekly to explain the current status of agency operations and initiatives. (*Id.*) When considered in light of the strain already imposed by the current and projected revenue shortfalls—and the fact that the statutory violation has been remedied—these costs simply cannot be justified on an ongoing basis.

3. Payments to Plaintiffs' Attorneys

In addition to the court monitoring fees, the District pays the plaintiffs a large sum in annual attorneys' fees. For the period 1997 through March 31, 2008, the District has paid Plaintiffs' attorneys a total of approximately $864,507.72 in fees and costs. (Declaration of Nekira Harris ("Harris Decl.) ¶ 4, attached at Exhibit 6.) In addition, Plaintiffs' attorneys have requested an additional $120,000 for the period June 1, 2008, through May 31, 2009, bringing the total requested or paid to almost one million dollars. (*Id.* ¶ 5 (citing figure of $984,507.72).) The District should not have to continue to pay for this routine monitoring activity by Plaintiffs' counsel, especially when the District has satisfied the underlying Ervin Act violation.

VI. THE REMAINING EXIT CRITERIA SHOULD BE VACATED BECAUSE THE DISTRICT HAS DEMONSTRATED SUBSTANTIAL, GOOD FAITH COMPLIANCE.

The foregoing discussion demonstrates that the District not only has remedied the underlying violations of law that gave rise to the initial exercise of this Court's jurisdiction and entry of the Consent Order but that significant changed circumstances support its vacatur. These grounds alone, especially given the Supreme Court's instruction in *Horne*, are sufficient to require dismissal of this case. In addition, however, or in the alternative, an independent ground exists for vacatur of the Consent Order—namely, the District has complied or substantially complied with the Court's exit criteria and it is in the interests of justice to dismiss the case. (*See* Consent Order at 2 (specifically allowing the District to move to dismiss when it has demonstrated "substantial compliance" with the exit criteria and the court holds that it is in the "interests of justice" to do so).)

A. Substantial Compliance

As noted above, because the District has remedied the underlying violation of law, this case should be dismissed under *Horne*. As discussed herein, and as demonstrated more fully in the attached appendix to this brief, however, the District also is in substantial compliance with the exit criteria established by the Court, which constitute independent grounds for vacatur of the Consent Order. In these circumstances, it is in the "interests of justice" to dismiss the case. (*See* Consent Order at 2.)

The "substantial compliance" analysis is similar to the analysis discussed in *Horne*—it requires the Court to evaluate, for example, whether the District has complied in good faith with the core purpose of the Consent Order; whether the purposes of the litigation have, to the extent practical, been achieved; and whether it is necessary or sensible, under current circumstances, for the Court to continue to exercise judicial oversight. *See, e.g.*, *United States v. City of Miami*, 2 F.3d 1497, 1508 (11th Cir. 1993); *Philadelphia Welfare Rights Org. v. Shapp*, 602 F.2d 1114 (3d Cir. 1979).

There is no question that the District has acted in good faith in achieving the purposes of the litigation, thus eliminating the need for Court supervision. Consistent with Court orders, the District has, in the last decade in particular, completed a comprehensive overhaul of DMH's structure, polices, and procedures relating to the provision of public mental health services, with the object and effect of maximizing community-based treatment. *See Dowell*, 498 U.S. at 249 (the "passage of time enables the district court to observe the good faith of the [local government] in complying with the decree").

It is important to note that good faith, substantial compliance does not require *full* compliance. Courts have found that a party has achieved substantial compliance with a consent decree, and accordingly have dismissed litigation, even where some noncompliance persisted. For example, in *Shapp*, the Third Circuit affirmed under Rule 60(b)(5) the district court's order modifying several exit criteria in a longstanding class action involving Pennsylvania's provision of early and periodic screening, diagnosis, and treatment to children under the age of 21. 602 F.2d at 1116. Even though it was undisputed that the state system had not met the numerical threshold of the specific exit criteria, due in part to imperfect inter-agency coordination, the court found that the defendants had demonstrated good faith compliance; indeed, Pennsylvania was shown to be exceeding national benchmarks. *Id*. at 1118, 1121.

Similarly, the Eleventh Circuit explained in *City of Miami* that even the stated purpose of a consent decree must be interpreted in light of the original violation that the decree is intended to remedy. In that case, the original violation consisted of "past discriminatory practices against blacks, Latins and women" in city hiring. 2 F.3d at 1507. The Eleventh Circuit held that the goal of correcting this violation informed the meaning of the decree's (seemingly broader) stated purpose, which was to "eliminate the substantial underrepresentation and uneven distribution of blacks, Latins and women throughout the City's work force." *Id.* As the court explained:

> Considering this language and the consent decree as a whole, we believe that the basic objective of the decree was to eliminate discrimination and the effects of past discrimination, which effects included the gross underrepresentation of minorities and women in certain segments of the City's work force. The long term goal of work force parity, or the shorter term goals regarding promotions and hiring, were not the "basic objectives" of the decree. Rather, these goals were a *means* of achieving and measuring progress toward the ultimate purpose of eliminating effects

> of past discrimination. The real aim is non-discrimination: not achieving parity is a failure *if caused by discrimination*, but not a failure if due to factors other than discrimination.

Id. at 1507-08 (emphases added).

The Eleventh Circuit again looked to a consent decree's original purpose, not merely its formalistic language, in affirming the dismissal of a longstanding class action decree in *R.C. v. Walley*, 270 F. App'x 989 (11th Cir. 2008). The *Walley* court held that, "after eighteen years of supervision, the Alabama child welfare system had undergone radical changes and was on secure footing to continue its progress in the years to come, without court supervision," notwithstanding the fact that the system "is not yet perfect and may never be." *Id.* at 992 (citing *Reynolds v. McInnes*, 338 F.3d 1201, 1219 (11th Cir. 2003)). In so holding, the court expressly relied on the state's "history of good faith and its present commitment to remedying remaining problems." *Id.* at 993.

The same rationale applies equally here: because the purpose of the Consent Order has been achieved, some minimal noncompliance with the exacting requirements of the exit criteria does not preclude termination of the Consent Order. *See Labor/Cmty. Strategy Ctr. v. L.A. County Metro. Trans. Auth.*, 564 F.3d 1115, 1123 (9th Cir. 2009) (adhering to "the principle that federal court intervention in state institutions is a temporary measure and may extend no longer than necessary to cure constitutional violations"), citing *Dowell*, 498 U.S. at 248; *Walley*, 270 F. App'x at 993 ("[F]ederal courts should not be in the business of running important functions of state government for decades at a time.") (internal quotation marks omitted).

As the case law makes clear, perfection is not required; the question is whether a decree has served its primary purpose, with sufficient systemic improvement to bring the litigation to a close. The answer here is an unequivocal yes.

B. The Remaining Exit Criteria

Six exit criteria have already been either designated inactive or recommended for inactive designation, including one related to treatment of children. These include criteria 8 (penetration—adults with serious mental illness), 12 (newer-generation medications), 13 (homeless adults), 16 (homeless children/youth), 18 (community resources), and 19 (Medicaid utilization).[21]

In evaluating the remaining exit criteria, the Court must limit its consideration to those that actually apply to the remaining *Dixon* class members, defined as "all persons who are now or who may be hospitalized in a public hospital pursuant to 21 D.C. Code § 501 *et seq*., and who need outplacement from that public hospital, as presently constituted, into alternative care facilities, such as nursing homes, foster homes, personal care homes and half-way houses, in order to receive suitable care and treatment in the least restrictive setting possible." (Feb. 7, 1975 Order.) Because Saint Elizabeths' children's ward was permanently closed in 2000, minors are no longer at risk of hospitalization at Saint Elizabeths. (*See* Baron Decl. ¶ 6.) Therefore, the *Dixon* class no longer includes children.

As a result, the criteria pertaining to children and youth—specifically, criteria 4 (Consumer Service Reviews – Children), 5 and 6 (penetration rates), 14 and 15 (services

[21] Specifically, criterion 12 has been inactive since July 2007; criterion 19 has been inactive since January 2008; criterion 18 has been inactive since July 2008; and the court monitor recommended in his January 2009 report that criteria 8, 13, and 16 be designated inactive.

in natural settings and/or home), 16 (engagement of homeless children and youth), and 17(b) (continuity of care – children/youth)—should be vacated, since they are no longer reasonable and necessary to remedy a violation of the *Dixon* decree. *Cf. Kremens v. Bartley*, 431 U.S. 119 (1977) ("[T]he metes and bounds of the class certified by the District Court have been carved up by two changes in the law. . . . this intervening legislation has rendered moot not only the claims of the named plaintiffs but also the claims of a large number of unnamed plaintiffs. The legislation, coupled with the regulations, has in a word materially changed the status of those included within the class description.").

As explained in detail in the appendix hereto (attached at Exhibit 7), while DMH may not have satisfied each and every detail of each and every exit criterion, the District has reached substantial compliance with the 7.5 exit criteria that remain both active and applicable—namely, criteria 1 (consumer satisfaction method(s)), 2 (consumer functioning method(s)), 3 (consumer reviews – adult), 7 (penetration—adults 18+ years), 9 (supported housing); 10 (supported employment), 11 (assertive community treatment), and 17(a)(continuity of care – adults).

For this reason alone, the Consent Decree should be vacated and the case dismissed.

VII. CONCLUSION

With due credit to the Plaintiff class, court monitor, and the Court's diligent supervision, the system has been reformed. And there is no going back. Institutional reform litigation loses its way when it begins to focus on perfecting the policies of an

agency rather than on correcting substantive legal violations; the perfect should not become the enemy of the good.

Plaintiffs will no doubt respond with specific examples from the court monitor's reports identifying the supposed "much work that remains." But, though the process of improvement never will (and never should) end, this case is not about creating an ideal system. The District should not be held captive to Court orders that reach far beyond remedying the lack of community-based facilities found in 1975.

The facts demonstrating the remediation of the underlying violations of law; changed circumstances, including the complete transformation of the mental health delivery system and the heavy costs that this litigation continues to impose; and evidence of substantial compliance with the exit criteria all provide independent and separate grounds requiring that the Consent Order be vacated and the case be dismissed.

Exhibit 1
Baron Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF STEPHEN T. BARON

I, Stephen T. Baron, pursuant to 28 U.S.C. § 1746, do hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am competent and have personal knowledge of the facts, or have ascertained the following to be true.

2. I am over the age of 18.

3. I am currently employed by the District of Columbia as the Director, Department of Mental Health. I have been employed in this position since April, 2006 first as the Acting Director and confirmed by the District of Columbia's Council in July, 2006.

4. The Department of Mental Health provided community-based services to 98% of consumers, or 11,819 adults, during FY 2008.

INPATIENT ISSUES

5. Reducing the hospital census on the civil side supports the goal of consumers of being treated in the least restrictive environment. DMH has put into place a number of strategies to accomplish this reduction , including establishing more acute care beds in

general hospitals for involuntary patients ; and establishing more intensive and appropriate services to meet the needs of long term patients at Saint Elizabeths who with the appropriate range of services no longer need care in the District's public psychiatric hospital.

6. On August 9, 2009, the number of inpatients ("census") at Saint Elizabeths Hospital was 370. Of these patients, only 217 were "class members" in that they were or may be subject to the Ervin Act. The remaining 153 individuals are at Saint Elizabeths pursuant to a criminal court order, either post-trial, having been found Not Guilty by Reason of Insanity ("NGRI") or confined as sexual psychopaths pursuant to the Miller Act; or are pre-trial and have been determined competent and are awaiting trial. A few (30) of the 217 subject to the Ervin Act are at Saint Elizabeths hospital under a criminal court order but, because they have been or may be found incompetent to stand trial, and thus civil commitment proceedings may be initiated against them, they fall within the class. The remaining 187 patients are called "civil" patients because they are not at the hospital under a criminal court order. Also, it is important to note that children are no longer housed at St. Elizabeths; the children's ward closed permanently in 2000.

7. For FY 2008, only 400 individuals were admitted to Saint Elizabeths Hospital pursuant to D.C. Official Code §21-501 *et seq*. ("the Ervin Act") (i.e. not due to a criminal court order). In FY 2003, 1800 individuals were admitted to Saint Elizabeths Hospital pursuant to the Ervin Act. This drop in admissions is due mostly to the additional acute care beds DMH has contracted for with United Medical Center, Psychiatric Institute of Washington (PIW) and Providence Hospital for involuntarily hospitalized individuals. [Please see affidavit of Jana Berhow to view data regarding admissions.]

8. DMH has been working closely with community providers to discharge more long-term patients to the community when clinically appropriate. For instance, DMH staff are meeting with community nursing home staff to encourage them to take appropriate Saint Elizabeth patients with the necessary supports. DMH is also working closely with DDS to join resources so that individuals with both mental health and mental retardation issues can be appropriately outplaced. And the new Integrated Community Care Project, run by Washington Hospital Center, is resourced to eventually outplace 30 long-term patients who can be outplaced with intensive services. [Please see affidavit of Jana Berhow for additional information on this program.]

COMMUNITY SERVICES

9. The District provides services to the majority of its mental health consumers in the community through Core Service Agencies ("CSA"s) which are certified by the Department of Mental Health to provide Mental Health Rehabilitation Services ("MHRS") to individuals in the community. Services include (1) Diagnostic/ Assessment; (2) Medication/Somatic; (3) Counseling; (4) Community Support; (5) Crisis/Emergency; (6) Rehabilitation/Day Services; (7) Intensive Day Treatment; (8) Community Based Intervention ("CBI"); and Assertive Community Treatment ("ACT").

10. DMH operated its own CSA, the District of Columbia Community Service Agency ("DCCSA") but over the past year has been in the process of closing it and transferring the majority—3200—of the 4000 consumers to the privately operated CSA's. The remaining 800 will stay with DMH either due to the specialized programs they are enrolled in, or because they are only receiving medication management and choose to stay with a District government psychiatrist.. On August 1, 2009, the DCCSA ended all

operations, and the Mental Health Authority of DMH under the Office of Programs and Policies assumed all remaining programs of the DCCSA, including the treatment of the remaining consumers. As of August 24, 2009, 2515 consumers had been assigned to private providers.

ACT

11. One service that is provided to the consumers at the highest risk of hospitalization due to their level of illness and difficult in being treated is Assertive Community Treatment ("ACT"). MHRS regulations require that the majority of ACT services - 60% - be provided to the consumer outside of the office setting. DMH is committed to expanding capacity to provide ACT and, in its 2009 Performance Management Plan, established a long term goal of doubling capacity by the end of FY 2011 (from a baseline of 440 to 850). In order to increase the capacity within the District to offer ACT services, DMH in conjunction with the Department of Health Care Finance ("DHCF") increased ACT reimbursement rates by 25% effective November 1, 2008 . As a result of that and improved training, education, and referrals, ACT enrollment has increased from 390 individuals to 535 individuals (June 1, 2009). Two providers, Community Connections and Green Door, have been recently certified as ACT providers, while Anchor Mental Health has an application pending. The District's capacity to provide ACT services has now increased to 700 individuals.

HOUSING

12. The District also has a significant community housing program for individuals with mental illness. As of June 30, 2009, DMH provides direct financial support, or facilitates, housing for over 2000 consumers (approximately 18% of adults with SMI).

Housing options that DMH has a direct role in supporting include Community Residence Facilities ("CRF's"), for individuals who need 24-hour supervision; Supervised Independent Living homes for individuals who do not need 24-hour supervision but who are not yet capable of being completely independent; and permanent supportive housing for individuals who are able to live on their own.

13. Five hundred and ninety-five (595) consumers reside in CRF's in the District of Columbia. DMH is responsible for licensing all CRF's in the District to ensure the facilities meet a minimum level of quality necessary to ensure the proper care of the residents. CRF's are divided into two categories: independent CRF's which are licensed by DMH but have no contractual relationship with DMH (378 consumers); and contracted CRF's, for which DMH pays the operators approximately $100 a day per consumer to provide additional care for the most mentally ill residents (217 consumers). CRFs provide an important housing option for individuals many of whom have previously had long stays at Saint Elizabeths and co-existing medical and psychiatric illnesses. Without the existence of these CRF's many individuals would have no alternative but to remain in the hospital.

14. DMH also licenses all Supervised Independent Living Facilities ("SIL's") in the District of Columbia. SIL's are for those individuals who do not need 24-hour care and receive their ongoing support from community providers. DMH contracts for 461 SIL units for DMH consumers. SIL provides a safe home-setting that includes community support within the consumer's living environment, which fosters recovery from mental illness while the individual is living independently. Services include training in life skill

activities, home management, community-services, and additional supports as needed. The CSA also conducts weekly home visits and monitoring.

15. DMH is also committed to providing opportunities for individuals to live independently in the community. Many individuals with a serious mental illness desire to have their own apartments in the community but face affordability challenges. DMH recognizes this and is able to provide financial supports in several ways. First, DMH provides direct housing subsidies to 750 consumers at a cost of $5.5 - $6 million annually. Neither Maryland nor Virginia provides a locally funded subsidy for mental health consumers to obtain permanent supported housing. Secondly, DMH has provided a $14 million in funds to the District Housing and Community Development ("DHCD") to provide grants for the building or renovation of 300 housing units to be specifically used for individuals with mental health issues. Currently, 239 units are under construction, renovation or contract, and the first 40 have already been filled. DMH has additional referral programs funded through federal grants for affordable independent housing for 374 DMH consumers.

16. Due to an informal survey conducted through the National Association of State Mental Health Program Directors ("NASMHPD") and discussions with other state directors of the mental health programs, I believe the District offers more community-based housing for the mentally ill, per capita, than the majority of states. I believe that the Department of Mental Health is in the top 20% of the nation for providing affordable housing for the mentally ill.

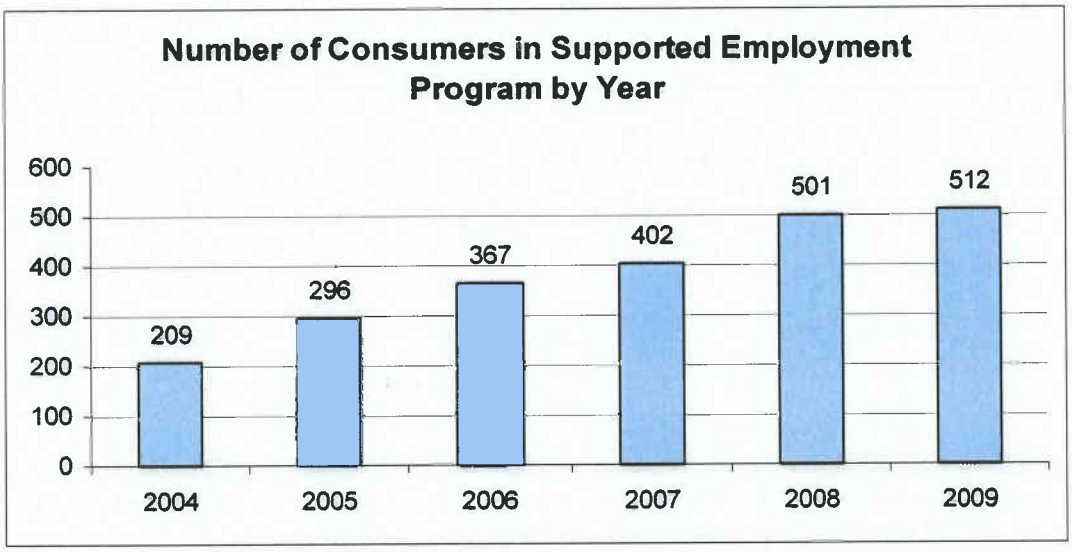
SUPPORTED EMPLOYMENT

17. The District also has operated a Supported Employment program since 2003. DMH offers an evidence-based Supported Employment program which operates with six core principles: 1) competitive employment is the goal; 2) supported employment is integrated with mental health treatment; 3) service eligibility is based on the consumer's choice; 4) consumer preferences are important; 5) job search starts soon after a consumer expresses interests in working; and 6) follow-along supports are continuous. The purpose of Supported Employment is to sustain community integration and support consumers in a least restrictive environment. Supported Employment involves obtaining a part-time or full-time job in which a consumer receives supports in a competitive employment setting and in which the consumer earns at least minimum wage.

18. As of June 1, 2009, 512 consumers were receiving supported employment services. The maximum capacity for the program is 550 consumers, however with a new contract from the Rehabilitative Services Agency ("RSA") of the Department on Disability Services ("DDS"), the number of consumers who can be in the program will increase to 660 by the end of FY 10 and to 700 by FY 11.

19. Since the inception of the Supported Employment Program, more than 30 consumers have "graduated" from the program entirely, in that they have maintained steady employment for more than a year. As a result, they no longer need active services from the Supported Employment Program.

20. The program has grown substantially since 2004 until 2009 (up 245%) as demonstrated by the following chart:



21. For fiscal year 2008, 93.75% of consumers who are referred to the Supported Employment program receive supported employment services within 120 days of referral. Currently, the percentage is 92%. Therefore, DMH has exceeded the Dixon Exit Criterion 10 performance benchmark of 70% served within 120 days of referral for the past two years.

22. In fiscal year 2008 seven programs provided evidence-based supported employment services funded by DMH: Anchor Mental Health, Community Connections, Inc., D.C. Community Services Agency, Deaf Reach, Inc., Green Door, Inc., Pathways To Housing, Inc., and Psychiatric Center Chartered, Inc. DMH monitors each of these programs, including an annual fidelity assessment of the supported employment providers (from 2004 through the present), collection and analysis of data regarding provider referral patterns for supported employment services (from October 2007 through the present), and quarterly claims audits conducted by the Office of Accountability (starting in October 2008 for services rendered in fiscal year 2008 and forward. As part of the closure of the

DCCSA, the consumers who were receiving supported employment services form the DCCSA are being absorbed by the other supported employment service providers.

EXIT CRITERIA 9, 10, and 11

23. When exit criteria 9 (Supported Housing); 10 (Supported Employment), and 11 (ACT) were negotiated, there were no national standards for measurement of access to evidence-based practices. In a recent review of other jurisdictions, DMH has been unable to verify that any mental health system measures these particular services in the manner required by the exit criteria. As demonstrated by DMH's efforts with regard to the funding, support and expansion of each of these evidence-based practices, they are valued and supported by DMH and its provider system, DMH has over the last few years successfully increased capacity to provide Supported Housing, Supported Employment and ACT services and has put in place structures to ensure their continued growth.

HOMELESS SERVICES

24. The District also offers a number of services for people who are homeless and also mentally ill. The Homeless Outreach Program's ("HOP") mission is to reach out to the homeless who face an increased risk of psychiatric emergencies due to their lack of family and community supports. As part of its mission, HOP team members visit shelters, locate missing consumers, and provide additional outreach. From April 1, 2008 through March 31, 2009, the HOP provided services to 1,330 different adults and 185 different children through a total of 3,465 face-to-face contacts.

25. The District also provides service to homeless individuals through contracts with mental health providers. Since FY 06, DMH has provided grant funds to the Recovery House at N Street Village ("N Street Village"). N Street Village provides services to homeless

women in the District who are mentally ill and have a co-occurring substance abuse disorder. In FY 08, DMH awarded a contract to Catholic Charities at Hermano Pedro Day Program, located in the Columbia Heights area of the District, to increase services to homeless individuals. As required by Exit Criteria 13 and 16, DMH memorialized its strategy for serving the homeless and mentally ill in a plan, which was approved by both the Court Monitor and the Dixon plaintiffs' counsel. As a result of all of these services, Exit Criteria 13 and 16 relating to homeless services have been moved to inactive status.

CRISIS SERVICES

26. Crisis services are available for those individuals who suffer a psychiatric emergency while in the community. The Comprehensive Psychiatric Emergency Program ("CPEP") is where individuals in a psychiatric crisis are often brought for psychiatric evaluations. The CPEP staff determines if a person is suffering for a psychiatric crisis; if so, the person is evaluated to determine if they need actual hospitalization and if the hospitalization is voluntary or involuntary. Even if involuntary, the person is transferred usually to a community hospital. DMH has contracted with Providence Hospital, United Medical Center ("UMC") and Psychiatric Institute of Washington ("PIW") to accept individuals who may be involuntarily hospitalized with the purpose of reducing direct admissions to Saint Elizabeths Hospital. CPEP also has Extended Observation Beds ("EOB") in which individuals can stay for up to 72 hours which often is long enough to stabilize a person and return them to the community. [Please see affidavit of Cynthia Holloway to view data regarding admissions.]

27. DMH also funds 15 crisis/respite beds through contracts with two private providers, Crossing Place and Jordan House. Crisis beds are for voluntary consumers who do not

need hospitalization but require more intensive care than can be provided in their homes in the community. DMH authorizes a consumer's use of a crisis bed for up to fourteen (14) days, and can extend the time when necessary for the consumer's needs. Since October 1, 2008, 375 consumers have been referred to the crisis beds from hospitals, CSAs, and families or consumers themselves, allowing them to stay in the community for their short-term oversight and care or to be discharged earlier from the hospital.

28. A significant development over the past two (2) years has been the implementation of adult mobile crisis teams, developed through a DMH-community work group consisting of representatives from DMH, the Metropolitan Police Department ("MPD"), Fire and Emergency Medical Services ("FEMS"), Department of Health ("DOH"); community advocates; mental health providers; mental health consumers; crisis bed providers; and representatives from the court system. The Adult Mobile Crisis Services ("MCS") began operation in November 2008. MCS is staffed by 18 multi-disciplinary team members, including social workers, mental health counselors and addiction treatment specialists. MCS members not only respond to emergency calls, but also provide counseling, assessments, assist with transportation, coordinate follow-up referrals, and general outreach. [See affidavit of Cynthia Holloway for data on MCS services.]

29. The District has contracted with Catholic Charities to provide mobile crisis services to children under the Child and Adolescent Mobile Psychiatric Service ("ChAMPS"). From October 2008 to June 30, 2009, ChAMPS has received over 500 calls; every quarter the percentage of children who has to be hospitalized following a call has decreased, from 25% the first quarter of operations (October – December 2008); to 11% the second quarter; and 5% the third quarter of operations (April – June 2009).

OVERSIGHT

30. Other organizations also provide oversight of DMH operations. In the past two years, the District of Columbia Office of the Inspector General ("OIG") has audited the DMH Educational Services, including the School-Based Mental Health Program (November 2008), Provider Reimbursements (December 2007) and DMH's "Implementation of Annual Financial Statement Audit Recommendation for FY 2008" (August 2009). The D.C. Auditor selected DMH's 2008 Performance Accountability Report ("PAR") for audit in the summer of 2009. The audit examined DMH's performance in areas relevant to *Dixon* including community-based psychiatric crisis services and improved Community Service Review scores. The final report will be issued before the end of 2009 and the information will be utilized to evaluate DMH's performance in meeting its own internal goals. Finally, the General Accounting Office can also evaluate DMH; the last such audit occurred in 2003.

COSTS

31. From fiscal year 2003 to 2009, the District has paid or allocated $3,413,622.96 for the services of the court monitor. This does not include the substantial loss of staff time incurred in meeting with the court monitor bi-weekly to explain the current status of agency operations and initiatives.

DEFINITION OF CARE

32. Tertiary Care is defined as highly specialized medical care usually provided over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in specialized facilities. Secondary Care, or acute care, is defined as medical care provided by a specialist or facility upon referral by a primary

care physician or emergency room. Custodial Care, as used in terms of treatment provided at St. Elizabeths, is defined as care primarily provided in a hospital-setting even though the individual is eligible, consistent with health needs, to be treated in the community.

EXIT CRITERIA 2

33. To comply with this criterion, in April 2005, the District adopted a Level of Care Utilization System ("LOCUS/CALOCUS") Evaluations to ensure that on-going level of care needs are effectively evaluated for all consumers enrolled in a CSA. DMH adopted Policy 300.1 Level of Care Utilization Systems (LOCUS/CALOCUS) Evaluations on April 25, 2005. The policy required DMH providers to complete a LOCUS (adults) or CALOCUS (children) evaluation when a change in level of care was requested (hospital admission, PRTF admission, etc.) or at a minimum, every ninety (90) days. LOCUS evaluation (CALOCUS for children) allows a provider to assess a consumer's functioning in a variety of domains; the lower the final score, the more assistance and services the consumer requires. Providers have completed LOCUS/CALOCUS evaluations and provided the results of the evaluations to DMH, through the Access Helpline to support requests for authorization of higher levels of care or specialized services (psychiatric hospitalization, ACT, etc.). The court monitor took the position that DMH needed to be able to aggregate and analyze the LOCUS/CALOCUS data in order to exit from court oversight. Accordingly, in the summer of 2008, DMH began implementing a web-based version of LOCUS/CALOCUS, which will facilitate the aggregation and analysis of consumer functioning data required by the Court Monitor. The policy was revised on May 8, 2009.

9/2/09
Date

Stephen T. Baron

Exhibit 2
Holloway Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF CYNTHIA HOLLOWAY

I, Cynthia Holloway, pursuant to 28 U.S.C. § 1746, do hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am competent and have personal knowledge of the facts.

2. I am over the age of 18.

3. I am currently employed by the Department of Mental Health ("DMH") as the Director, Comprehensive Psychiatric Emergency Program ("CPEP"). I have been employed by DMH since May 2005.

4. CPEP is a 24-hour 7-days a week program providing acute psychiatric and medical screening for individuals brought for emergency detention pursuant to D.C. Official Code § 21 – 521, and/or for individuals needing emergency observation and diagnosis for suspected acute psychiatric crisis. Staff at CPEP conduct crisis intervention services, psychiatric screening and stabilization, hospital pre-screening and mental status evaluations to make a determination of the least restrictive environment necessary to treat

the individual, with the capacity to continue the emergency observation and diagnosis for a period not to exceed 72 hours.

5. In FY 2008, 3621 people were admitted to CPEP. Of that number, 1551 were discharged to return to the community, either to "self-care" or in a supported housing program. 35% or 1268 were discharged for psychiatric hospitalization, 365 to Saint Elizabeths Hospital, and 903 to a community hospitals such as United Medical Center or the Psychiatric Institute of Washington. 133 were discharged to the crisis beds at Crossing Place and Jordan House; 264 consumers to a substance abuse program, and 47 to a hospital for medical treatment. Between October 2008 and June 30, 2009, 3132 consumers have been admitted to CPEP. Of those, only 874 or 28% were discharged to hospitals for psychiatric care. The remainder was discharged primarily to "self care" in the community (over 70%); other discharges included transfer to hospitals for medical care; or substance abuse programs.

6. Thus from October 2007 to June 2009, CPEP served over 6000 consumers. The majority of patients (almost 4000) were stabilized and discharged directly to the community without further hospitalization, usually to self-care, but sometimes in conjunction with other services such as supportive housing or substance abuse programs. In the past, before the creation of CPEP and other crisis services, these patients risked hospitalization at Saint Elizabeths.

7. DMH funds 15 crisis beds maintained by two private providers: Crossing Place (Woodley House, Inc.) and Jordan House (SOME). Crisis beds are for individuals who do not need hospitalization but do need more services than can be provided at home. DMH authorizes an individual to use a crisis bed for up to fourteen (14) days, with

extensions possible if needed. Between October 1, 2008 and June 30, 2008, 114 consumers were discharged to the crisis beds from CPEP.

8. In FY 2009, two new services began. The first was the Mobile Crisis Service (MCS) which began operations in November 2008. The MCS is staffed by 18 multi-disciplinary team members, including psychiatrists, social workers, mental health specialists, mental health counselors, peer counselors, and addiction treatment specialists. Team members not only respond to emergency calls but also provide counseling, assessments, transportation assistance, follow-up referrals, and outreach. Since November 2008, MCS has provided services to an average of 170 different consumers every month. Notably, over 70% of the consumers that MCS responded to were maintained in the community following contact with the MCS and did not have to be transported to CPEP.

9. Eight (8) Extended Observation Beds ("EOB") opened in February 2009. EOB's allow consumers to stay at CPEP for up to 72 hours, which provides DMH with additional flexibility to stabilize psychiatric emergency patients in a less-restrictive environment than a hospital, when possible. Out of 122 patients who were admitted to an EOB between February and June, 2009, only 25 had to be admitted to a hospital for psychiatric treatment.

9/2/09
Date

Cynthia Holloway

Exhibit 3
Berhow Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF JANA BERHOW

I, Jana Berhow, pursuant to 28 U.S.C. § 1746, do hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am competent and have personal knowledge of the facts.

2. I am over the age of 18.

3. I am currently employed by the Department of Mental Health ("DMH") as the Director of the Integrated Care Division in the Office of Programs, DMH. I have been employed by DMH since 2002.

4. The ICD identifies and manages care for individuals who have high needs and are in need of service coordination. This includes individuals who have had multiple psychiatric inpatient admissions, multiple admissions to CPEP and episodes of homelessness and incarceration. In addition, the ICD also focuses on individuals discharged from Saint Elizabeths and from the DMH-contracted acute inpatient care settings to ensure that they

are receiving the recommended course of treatment in the community. Currently the ICD is providing oversight of the care for 244 consumers. As part of this effort, DMH has developed a "barriers to discharge" list identifying those consumers with special needs that may be impeding their discharge from the Hospital.

5. The ICD tracks consumers when they are discharged from the hospital to determine when they have their first appointment in the community, both to ensure that the individual is successfully connected to community services and in order to collect data for exit criterion 17, Continuity of Care. Currently the requirement for moving the criteria to inactive status is that 80% of individuals be seen in the community within seven (7) days of discharge. However, as reported by the National Committee for Quality Assurance ("NCQA") for 2008, the District is tied with New York as the highest performing state with a rate of 54.4%. DMH requested the court monitor modify the standard for the exit criteria from 80% to 60%, in accordance with the national data, but the court monitor has refused.

6. The ICD is an integral part of the DMH strategy to better serve individuals most in need and to ensure they receive the proper range of services. The ICD is staffed with four (4) masters' level, clinically licensed staff who report to me as the director of Integrated Care. By providing authority level care management the goal is to help consumers stay in their communities and their desired settings to their maximum ability and desire.

7. The ICD also manages the Integrated Community Care Project, a pilot program designed to serve at a minimum thirty (30) long-term Saint Elizabeths patients who have had significant challenges to discharge but with significant individualized services are ready to be discharged into the community. Washington Hospital Center (WHC) has the

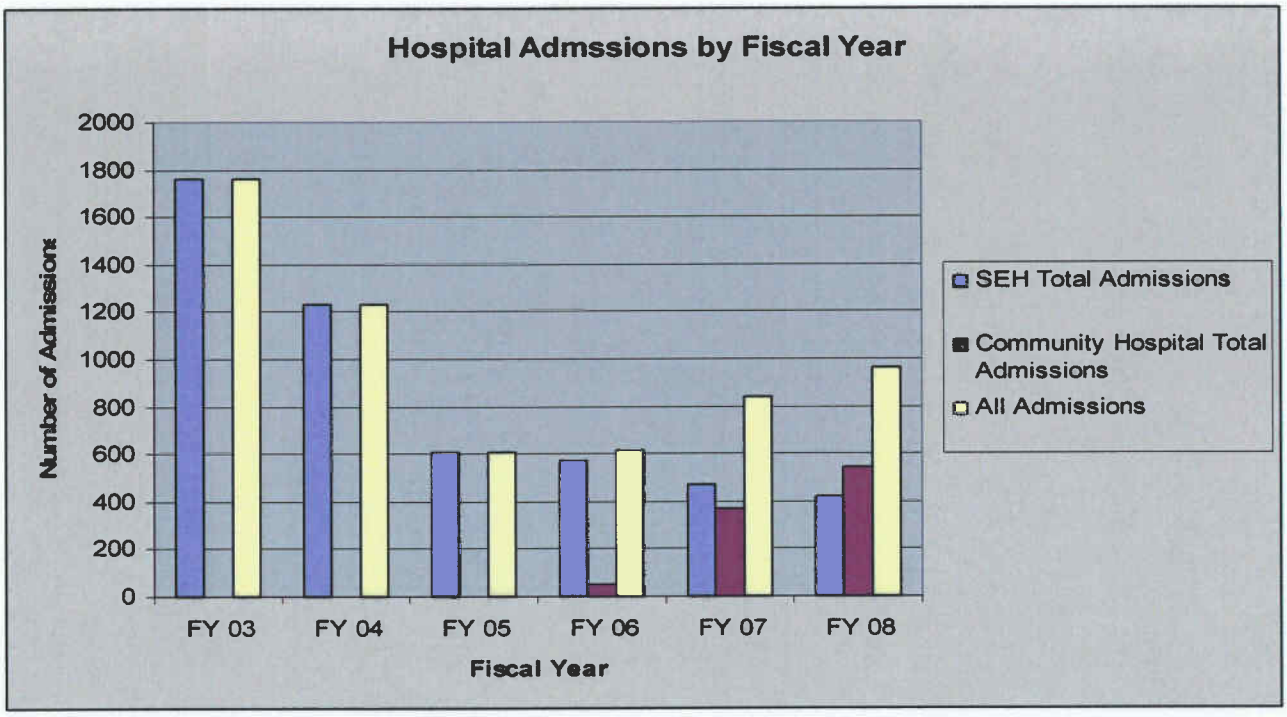
contract to provide 30 patients with these intensive supports. WHC has titled this program New Directions and since March 26, 2009, when the contract was finalized, 19 consumers have been enrolled; four (4) more should be accepted by September 30, 2009. The goal is that they will be working with the hospital staff to discharge 3-5 consumers per month until they reach full capacity. One (1) individual has been successfully discharged into the community through the assistance and extra support of the Integrated Community Care Project. It is expected that four (4) individuals with the same or longer-term histories in the hospital with be discharged within the next month.

8. I also track all discharges from Saint Elizabeths for civil patients – that is, those individuals who are hospitalized pursuant to the Ervin Act, not pursuant to a criminal court order. DMH is now discharging an average of 30 Ervin Act patients – or 16% of its average civil population – every month.

9. One of my responsibilities is to track all acute care admissions authorized by DMH. I track the number of patients admitted, the hospital to which they were admitted, and, if applicable, the reasons that the person(s) was admitted to Saint Elizabeths Hospital instead of a community acute care hospital. I have been tracking this information for the past 7 years. The following chart is, to the best of my knowledge and information, a true and accurate chart of the acute care admissions to Saint Elizabeths for FY 2009 (October 2008 to July 31, 2009):

Total Admissions By Facility	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Total
United Medical Center (UMC)	36	38	38	41	42	41	27	38	12	0	313
Psychiatric Institute of Washington (PIW)	0	0	0	0	0	0	0	1	10	10	21
Providence	14	18	20	13	25	22	26	32	35	55	260
St Elizabeths – Acute (SEH)	20	16	18	19	5	1	3	4	6	12	104
St Elizabeths – 15 Day Transfers (SEH)	10	8	14	21	12	13	13	11	16	11	129
Sub Acute (Inpatient Psychiatric Bed)	3	1	2	8	9	6	1	6	2	5	43
Total	83	81	92	102	93	83	70	92	81	93	870
Legal Status of SEH Admissions - All	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Total
Committed Outpatient	3	2	7	2	3	0	0	0	4	3	24
Involuntary	17	22	26	17	21	20	17	20	17	25	202
Voluntary	1	1	0	0	2	0	0	0	3	0	7
Admissions without Care Coordination Authorization	2	0	1	3	0	0	0	1	0	0	7
Referral Source of Admissions to SEH	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Total
Community Emergency Room	4	3	3	1	1	0	0	1	1	2	16
Inpatient Medical/Surgical Bed	0	0	2	0	0	0	0	1	0	1	4
Sub Acute (Inpatient Psychiatric Bed)	3	1	2	8	9	6	1	5	2	4	41
CPEP	11	13	14	7	4	1	3	2	5	10	70
UMC 15 Day Transfer	5	7	10	15	8	7	7	2	6	0	67
PIW 15 Day Transfer	0	0	0	0	0	0	0	0	0	1	1
Providence 15 Day Transfer	5	1	3	6	4	6	6	9	10	10	60
Unknown	0	0	0	0	0	0	0	1	0	0	1
Total Admissions In Which SEH Was Only Option	20	9	27	11	22	19	14	17	24	20	136

10. The following bar graph is, to the best of my knowledge and information, a true and accurate depiction of the acute care admissions to Saint Elizabeths and to the community hospitals from FY 2003 through FY 2008. As you can see the acute care admissions to Saint Elizabeths Hospital decrease over time as DMH has implemented greater capacity within the community hospitals.



11. In addition, because the Ervin Act specifically requires the discharge of any hospitalized patient within 14 days when recommended for outpatient treatment by the Commission on Mental Health ("Commission"), over 100 consumers have been out-placed from the Hospital since January 2007, in accordance with this provision.

9/1/2009
Date

Jana Berhow

Exhibit 4
Weiss Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF ANNE WEISS

I, Anne Weiss, pursuant to 28 U.S.C. § 1746, do hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am competent and have personal knowledge of the facts.

2. I am over the age of 18.

3. I am currently employed by the Department of Mental Health ("DMH") as the Deputy Director DMH, Accountability. I have been employed by DMH since December 2006.

4. Although quality improvement is integral to all of programs with DMH, the Division of Quality Improvement within the Office of Accountability ("OA") has the primary responsibility for formal Quality Improvement ("QI") programs and coordinates QI efforts throughout the agency.

5. DMH has an Internal Quality Committee ("IQC") which is scheduled monthly to review and evaluate QI initiatives, as well as priority areas such as major unusual incidents and mortality reviews; high-end utilization of community support (a specific type of MHRS

service); the treatment plan format; and consumer satisfaction reports. The IQC has also developed the provider's "score card."

6. DMH also has an external Quality Council which meets quarterly and includes the QI directors of all of the DMH-certified mental health providers. This ensures that all providers are involved in the development and implementation of QI priorities. Recent priority areas have included the implementation of the web-based LOCUC/CALOCUS application, which allows providers to track electronically a consumer's progress in specific domains, as well as identify needed changes in the level of care.

7. The "provider score card" is a recent creation currently in the pilot stage. The scorecard will allow a provider's quantifiable results – for instance claims audits results, timeliness of treatment plans, and LOCUS/CALOCUS compliance - to be tallied and compared against other providers. Following the pilot project, the scorecards will be available to the public in FY 10, so that consumers may have additional information on which to base their choice of provider.

8. DMH has three formal methods for measuring consumer satisfaction; the Mental Health Statistical Improvement Program ("MHSIP"); consumer satisfaction convenience surveys; and focus groups. The consumer satisfaction convenience surveys and focus groups are conducted by the Consumer Action Network ("CAN") though a contract with DMH. DMH has reviewed and refined the data derived from these methods and has rolled out several improvement quality initiatives as a result of the information already obtained.

9. The MHSIP is required as part of the Data Infrastructure Grant ("DIG") that DMH receives annually from the U.S. Department of Health and Human Services ("DHHS").

DHHS, Substance Abuse and Mental Health Administration ("SAMHSA") provides funding for the development of data infrastructure to the states and territories, awarded in the form of the DIG. Among other things, the DIG requires that the recipient jurisdictions conduct the MHSIP to collect consumer specific data on a variety of topics, including consumer satisfaction. DMH is required to report data collected through the MHSIP as part of its annual application for Mental Health Block Grant funds. Although in the past it has been a telephone-only survey, recent changes for this year include mail as well as telephone contact, and there may be face-to-face contact with those individuals chosen for the survey who were unable to be contacted otherwise.

10. CAN has been working closely with OA to refine its consumer satisfaction convenience surveys so that the results can be better used to identify issues and improve programs.

11. The focus groups that CAN operates have identified three priority areas, which have led to increased focus on those issues. For instance, one concern is about the continuity of care between physical health and mental health treatment. Therefore the CSA's are now required to review thirty (30) clinical records per quarter to ascertain if there is appropriate coordination of behavioral health and primary care. Each quarter, for those charts which show no evidence of coordination of care, the provider is required to remediate by the following quarter, in addition to pulling another random sample for review. By September 30th, 2009, at the end of the fiscal year, all data will be aggregated by OA, and an outcomes analysis will be performed. Based on that analysis, a similar but more complex initiative will be rolled out for FY10. Additionally, the Director of the Office of Consumer and Family Affairs ("OCFA") at DMH has been meeting with people in the District's Office of Disability Rights to develop a system for consumer

posting of medications and treatment plans on-line; DMH's Office of Programs is developing clinical practice guidelines to address care coordination issues; and DMH is participating in a citywide "Chronic Care Initiative Grant" with two CSA's as the pilot sites in the District.

12. OA also conducts annual claims and quality audits of every provider; bi-annual certification and off-year compliance inspections of every provider; mortality reviews, and investigations, as needed. Not only are the results of the quantifiable inspections used in the provider score card, any failures or problems may result in a Corrective Action Plan ("CAP") that must be developed by the offending provider. OA personnel monitor a provider's progress in complying with the CAP until the problem is fixed. For instance, from a recent review of providers' compliance with the LOCUS/CALOCUS requirements, corrective action plans were issued for those providers who were not assessing the consumers as required, and monitoring and follow-up evaluations are on-going.

13. A recent June 2009 review by the Medicaid Integrity Program of the Center for Medicare and Medicaid Services ("CMS") highlighted DMH as having a "comprehensive provider audit program" on which other District agencies could model their own audit programs.

9/2/09
Date

Anne Weiss

Exhibit 5
Bushlin Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
ADRIAN M. FENTY, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MERAV BUSHLIN

I, Merav Bushlin, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury under the laws of the United State of America that the foregoing is true and correct.

1. I am over eighteen years of age and I am competent to testify to the matters contained herein based upon personal knowledge.

2. I am currently the Budget Director in the Office of the City Administrator.

3. I reviewed the Chief Financial Officer's ("CFO") revenue projections for fiscal years 2009 and 2010. In September 2008, the CFO released a projection showing an estimated $130.7 million shortfall in fiscal year 2009 in local fund revenues. In December 2008, the CFO released a second projection with a revenue reduction estimated at an additional $127.1 million in fiscal year 2009. Revenue has continued to decline. In February 2009, the CFO estimated that revenue for fiscal year 2009 would decline by an additional $135 million. And in June 2009, the CFO determined that revenue for fiscal year 2009 would be further reduced by $190 million.

4. For fiscal year 2010, the projected shortfall is even more severe, totaling $952 million. The effect of the revised revenue estimates is reflected in the following chart:

Table 1: Local Fund Revenue estimates: Original to Current

	FY 2009	FY 2010
May 2008 estimate	$5,562,900,000	$5,831,700,000
Sept 2008 revision	($130,700,000)	($151,900,000)
Dec 2008 revision	($127,100,000)	($303,800,000)
Feb 2009 revision	($135,700,000)	($346,300,000)
June 2009 revision	($190,000,000)	($150,200,000)
Total Effect of Revisions	**($583,500,000)**	**($952,200,000)**
Revisions as % of May 2008 estimate	**-10.5%**	**-16.3%**

Executed on this 17th day of August, 2009.

MERAV BUSHLIN

Exhibit 6
Harris Declaration

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al., Plaintiffs, v. ADRIAN M. FENTY, et al., Defendants.	)	Civil Action No. 74-285 (TFH)

DECLARATION OF NEKIRA HARRIS

I, Nekira Harris, pursuant to 28 U.S.C. § 1746, do hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am competent and have personal knowledge of the facts.
2. I am over the age of 18.
3. I am currently employed as Paralegal Specialist with the Office of Attorney General for the District of Columbia.
4. I reviewed the electronic docket in the above-captioned case to determine the amount of attorneys' fees and costs paid by the District. Based upon my review, the amounts below could be confirmed. The total is $864,507.72.

DATES COVERED	AMOUNT	DOCKET NO.
1997 (unclear based on docket)	$207,000.00	113, Minute Order
November 1,1997 -March 31, 20009	$110,000.00	148, Consent Order
April 1, 2000 – April 30, 2001	$110,000.00	170, Consent Order
May 1, 2001 – May 30, 2002	$100,000.00	214, Consent Order
May 1, 2002 – May 30, 2003	$40,000.00	235, Consent Order
June 1, 2003 – May 31, 2004	$55,201.50	249, Consent Order
June 1, 2004 – May 31, 2005	$32,593.90	258, Consent Order
June 1, 2005 – May 31, 2006	$55,000.00	284, Consent Order
June 1, 2006 – May 31, 2007	$100,000.00	313, Consent Order
June 1, 2007 – May 31, 2008	$54,712.32	322, Consent Order
TOTAL	$864,507.72	

5. Also, based on a review of email, plaintiffs' counsel has indicated that they will be requesting an additional sum of $120,000.00 for the period June 1, 2008 – May 31, 2009. If this amount were granted by the Court, it would increase to the total to $984,507.72.

8/31/09
Date

Nekira Harris

Exhibit 7
Appendix - Exit Criteria

APPENDIX – DISCUSSION OF EXIT CRITERIA

Evaluation of the Exit Criteria

To the extent that any remaining performance requirements exist, they are not reasonable and necessary to remedy an ongoing violation of the Ervin Act and should therefore be vacated. Indeed, the *Dixon* exit criteria are completely unmoored from national standards and therefore do not measure *de jure* compliance with the Ervin Act. Thus, continued improvements, even if beneficial, must be left to local administrators without the imposition of intrusive court supervision and costly monitoring—especially where the District has demonstrated the most salient and fundamental element—*i.e.*, community-based capacity. *See Frew*, 540 U.S. at 442 ("As public servants, officials of the State must be presumed to have a high degree of competence in deciding how best to discharge their governmental responsibilities.")

Over the course of this now 35-year-old litigation, and particularly since 2002, *Dixon* has suffered from mission creep—extending far beyond the intent underlying the Court's original 1975 findings or the many orders that followed in its wake. The *Dixon* class continues to comprise those individuals who risk unnecessary hospitalization in Saint Elizabeths due to lack of alternative, community-based facilities. Now, however, the scope of the current exit criteria and court monitoring reach well beyond the particularized harm of unnecessary hospitalization to delve into a litany of initiatives and programs that are best left to the District (through DMH) to carry forward and improve.[1]

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[1] For example, the court monitor recently reported upon such subjects as "Claims Auditing of MHRS Providers"; "Integration of Data Bases"; "School-Based Mental Health Services"; "DMH Training Institute"; "Research and Clinical Informatics"; staffing of DMH contract office, and Office of Consumer and Family Affairs efforts to procure a new database. (*See generally* July 2009 Court Monitor Report.)

It is within this context that the Court must evaluate DMH's good faith efforts to substantially comply with the Consent Decree. Where, as here, it is in the interests of justice to do so, the Court should vacate the Consent Order and dismiss the case. (*See* Consent Order at 2.)

1. Exit Criterion 1—consumer satisfaction method(s)

Exit criterion 1 relates to the goal of developing and integrating a quality improvement mechanism. Specifically, it requires DMH to demonstrate both implementation and use of methods for assessing consumer satisfaction. (*See* Consent Order, appended "Agreed Exit Criteria with Measurement Methodology and Performance Levels" ("Exit Criteria") at 2.)[2]

DMH currently uses three (3) customer satisfaction methods: the Mental Health Statistical Improvement Program ("MHSIP"),[3] convenience sampling, and focus groups. (*See* July 2009 Court Monitor Report at 4-5.) Even though DMH has reviewed and refined the data derived from these methods and has implemented several improvement quality initiatives as a result of the information already obtained (Weiss Decl. ¶ 8, attached at Exhibit 4), the court monitor has not recommended this exit criterion for inactive status.[4] The court monitor insists on "a clear organizational process by which

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[2] Page numbers have been added for ease of reference. They were not included in the filed document.

[3] The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration ("SAMHSA") provides funding to the states and territories for the development of data infrastructure. This funding is awarded in the form of the Data Infrastructure Grant ("DIG"). Among other things, the DIG requires that recipient jurisdictions conduct the MHSIP to collect consumer-specific data on a variety of topics, including consumer satisfaction. DMH is required to report data collected through the MHSIP as part of its annual application for Mental Health Block Grant funds. (Weiss Decl. ¶ 9.)

[4] Moreover, where adjustments were needed in the surveys themselves, DMH has made those changes:

data from these three sources is aggregated and analyzed—followed by a process of prioritization, implementation and follow-up measurement of changes," and maintains that the District has not complied. (July 2009 Court Monitor Report at 4.)

The court monitor's observations do not justify continued oversight in the areas of consumer satisfaction and, more broadly, performance improvement. First, measurement of consumer satisfaction is not "reasonable and necessary" to remedy the underlying violation of the Ervin Act, because it does not gauge or increase community capacity, which is the underlying purpose of the 1975 *Dixon* Decree. Surveys or other methods are merely tools to obtain feedback from consumers and improve the quality of care in the system—a laudable goal that the DMH will continue to pursue, but not one necessary to ameliorate the original Ervin Act violation.

More importantly, DMH has an established quality improvement program. In addition to the internal and external quality improvement structure identified *supra* at 29-30, the Office of Accountability ("OA") conducts annual claims and quality audits of every provider; bi-annual certification and off-year compliance inspections; and investigations, thereby allowing DMH to monitor provider performance. (Weiss Decl. ¶ 12.)

As a result of the FY 2007 and FY 2008 audits, "provider score cards" are being piloted that, when complete, will provide information to the public on every provider's performance including timeliness of treatment plans and LOCUS/CALOCUS

> For the 2009 MHSIP survey, DMH is planning to change its contract requirements to include mail responses for unsuccessful telephone efforts. Additionally, a small cash incentive will be offered to participants. The goal is to sample approximately 1800 total individuals (adults and parents of children/youth). *These changes are all due to recommendations of the [DMH Internal Quality Council]*.

(July 2009 Court Monitor Report at 5 (emphasis added).)

requirements. (*Id.* ¶ 7.) This allows DMH to monitor provider performance and also allows consumers to make more informed choices when enrolling with providers. Also in June 2009, the Medicaid Integrity Program of the Center for Medicare and Medicaid Services ("CMS") found that DMH has a "comprehensive provider audit program," one on which other District agencies could model their own audit programs. (*Id.* ¶ 13.)

In short, DMH already has a vigorous quality improvement system and is measuring consumer satisfaction. Accordingly, the District has substantially complied with this criterion.

2. Exit Criterion 2—consumer functioning methods

Exit criterion 2 requires DMH to demonstrate use of consumer functioning review method(s) as part of its quality improvement system for community services. (*See* Consent Order, appended Exit Criteria at 2.) First, the same rationale that applies to exit criterion 1 applies *a fortiori* to exit criterion 2; this criterion is simply not necessary to ameliorate the original Ervin Act violation. Further, to comply with this criterion, in April 2005,[5] the District adopted a Level of Care Utilization System ("LOCUS/CALOCUS") Evaluations[6] to ensure that ongoing level-of-care needs are effectively evaluated for all consumers enrolled in CSAs. (Baron Decl. ¶ 33.) Providers have completed LOCUS/CALOCUS evaluations and provided the results of those

[5] DMH adopted Policy 300.1 Level of Care Utilization Systems (LOCUS/CALOCUS) Evaluations on April 25, 2005. The policy required DMH providers to complete a LOCUS (adults) or CALOCUS (children) evaluation when a change in level of care was requested (hospital admission, PRTF admission, etc.) or at a minimum, every ninety (90) days. The policy was revised on May 8, 2009. (Baron Decl. ¶ 33.)

[6] LOCUS evaluation (CALOCUS for children) allows a provider to assess a consumer's functioning in a variety of domains; the lower the final score, the more assistance and services the consumer requires. (Baron Decl. ¶ 33.)

evaluations to DMH, through the Access Helpline to support requests for authorization of higher levels of care or specialized services (psychiatric hospitalization, ACT, etc.). (*Id.*)

The court monitor, however, has took the position that DMH needed to be able to aggregate and analyze the LOCUS/CALOCUS data in order to exit court oversight. (*Id.*) Accordingly, in the summer of 2008, DMH began implementing a web-based version of LOCUS/CALOCUS, which will facilitate the aggregation and analysis of consumer functioning data required by the court monitor. (*Id.*) As the court monitor noted, the implementation of the web-based application of LOCUS/CALOCUS is "on track," and training is to be completed by August 31, 2009. (July 2009 Court Monitor Report at 5.) The court monitor further found that "DMH has clearly communicated to providers that LOCUS/CALOCUS must be completed on all consumers in accordance with DMH policy. OA has begun to review provider compliance with LOCUS/CALOCUS as part of its auditing process." (*Id*. at 5-6.) For those providers who were not assessing the consumers as required, corrective action plans were issued and monitoring and follow-up evaluations are ongoing. (*See id.*; *see also* Weiss Decl. ¶ 12.)

Despite these findings, the court monitor has declined to recommend this criterion for inactive status, asserting that "demonstrated use" must still be proven at both the system level and at the individual provider level. (July 2009 Court Monitor Report at 6.) *Horne* specifically rejected such hyper-technical bases for continued federal court oversight where, as here, the purpose of the underlying decree has been satisfied.

The District has substantially complied with exit criterion 2.

Exit Criterion 3—consumer reviews (adult)

This criterion requires DMH to conduct annual case reviews to evaluate how well the system is caring for its consumers. (*See* Consent Order, appended Exit Criteria at 2-5.) The benchmark system performance is 80%; DMH has scored 70% or higher two years in a row. (*See* July 2009 Court Monitor Report at 9 (noting 70%); July 2008 Court Monitor Report at 8 (noting 80%).) This consistently high standard of performance constitutes substantial good faith compliance in and of itself.

Moreover, the 80% benchmark is not based upon any national standard of care; rather, it is an arbitrary metric to which a previous administration unwisely agreed more than five years ago. Lacking any statutory basis for this numerical threshold, and given the District's strong and consistent performance, this exit criterion should be deemed substantially satisfied.

Exit Criterion 7—penetration (adults 18+ years)

This criterion requires DMH to demonstrate that it provides services to adults. (*See* Consent Order, appended Exit Criteria at 6.) The benchmark for performance is 3%. (*Id.*) DMH's current performance of 2.51 % constitutes substantial compliance with this benchmark. (*See* July 2009 Court Monitor Report at 9.) Moreover, DMH has already demonstrated compliance with the more salient indicator in Exit Criterion 8 (inactive), which requires DMH to achieve a penetration rate of 2% of adults with serious mental illness, its core consumer population. (*Id*. (noting rate of 2.38%).) This combined record of achievement substantially satisfies the purpose of exit criterion 7.

Exit Criterion 9—supported housing

It must be stated at the outset that when this exit criterion, as well as criteria 10 and 11 below, were negotiated, no national standards existed. (Baron Decl. ¶ 23.) The

standards selected, then, represented mere proxies about how to measure adequate access to these specialized services. Moreover, in a recent review of other jurisdictions, DMH has been unable to verify that any mental health system measures these particular services in the manner required by the exit criteria. (*Id.*) It is inappropriate to condition continued federal court oversight on compliance with an arbitrary benchmark, especially where it is demonstrated that the District provides a range of community-based treatment options and discharges patients from Saint Elizabeths at a "reasonable pace."[7]

For exit criterion 9, the parties settled on a requirement that 70% of consumers receive housing within 45 days of their referral. (*See* Consent Order, appended Exit Criteria at 6.) While this target may, at first blush, appear to be a relevant indicator of housing services, in reality, we now know that this benchmark percentage is impossible to achieve, as it requires an inexhaustible supply of available, low-cost housing. There have been numerous, ongoing discussions between DMH and the court monitor regarding possible modification of this criterion to a more realistic system performance metric. (*See* July 2009 Court Monitor Report at 29.) As stated *supra* at 17, the District's housing program is already in the top 20% nationwide. While the District can certainly influence the number of housing units available to serve the population and has done so in good faith, the District cannot defy economic reality to create additional housing on such a massive basis as to comply fully with this criterion.

Where compliance with a particular court order is beyond the District's control, that order should be vacated. *See Shapp*, 602 F.2d at 1121 ("Despite a good faith effort at

[7] Unfortunately, the court monitor's response to DMH's concern has been to suggest that DMH create an alternative measurement tool and then attempt to meet it. This approach suggests that court monitoring is the end in and of itself, as opposed to a tool for determining whether the District now provides a range of community-based housing sufficient to remedy the underlying violation of the Ervin Act.

compliance, circumstances largely beyond the defendants' control and not contemplated by the court or the parties in 1976 put achievement of the screening goals and treatment timetable beyond reach. The district court did not err in modifying both."); *New York State Ass'n for Retarded Children v. Carey*, 706 F.2d 956, 970-71 (2d Cir. 1983) ("Where an affirmative obligation is imposed by court order on the assumption that it is realistically achievable, the court finds that the defendants have made a good faith effort to achieve the object by the contemplated means, and the object nevertheless has not been fully achieved, clearly a court of equity has power to modify the injunction in the light of experience.") (internal quotation marks omitted).

In any event, the District submits that it has already substantially complied with this criterion by demonstrating sufficient housing capacity to discharge patients at Saint Elizabeths into the community at a "reasonable pace," which is the underlying purpose of the criterion. (*See* discussion, *supra*, at 23-26.)

Exit Criterion 10—supported employment

The parties determined that 70% of persons referred must receive supported employment services within 120 days of referral. (*See* Consent Order, appended Exit Criteria at 6.) In the most recent reporting period, DMH exceeded that benchmark by more than 20 percentage points, serving 90.4% of those referred within 120 days of referral. (*See* July 2009 Court Monitor Report at 9 (referring to the period April 1, 2008, through March 31, 2009).) The percentage for FY 2008 was 93.75%. (Baron Decl. ¶ 21.) Therefore, DMH has far exceeded the performance standard for this criterion for the past two years. (*Id.*)

Clearly, the District has substantially complied with this criterion and has demonstrated sustainability. Indeed, the court monitor reported most recently that he "[]continues to be impressed with the breadth and quality of the overall SE program." (July 2009 Court Monitor Report at 31.) And yet the court monitor has not recommended this criterion for inactive monitoring because DMH has not "verified referrals at the provider level." (January 2009 Court Monitor Report at 11; *see also* July 2009 Court Monitor Report at 11-12 (issue continues to be "lack of verification that CSA's are in fact making appropriate referrals").)

In declining to recommend inactive status despite the undisputed percentages, the court monitor has inappropriately injected an additional requirement into the analysis. The exit criterion is clear: it measures how many consumers are served within 120 days, as a percentage of those who have actually been referred:

> The number of adults (age 18 and over) with serious mental illness served by DMH who have received within a given period the identified services will be measured as a percentage of the total number of adults with serious mental illness service in the community *who have been referred to receive this service*.

(Consent Order, appended Exit Criteria at 13 (emphasis added).) Instead of following the plain language of the criterion, however, the court monitor is now requiring that DMH prove that all consumers who are eligible for supported employment are in fact being referred consistent with DMH policy. While this criterion could have been written to require such a showing, it was not.

More important, DMH has a formal policy related to Supported Employment, DMH Policy 508.1, and monitors its implementation. (*See* Exhibit 8.) DMH's monitoring includes an annual fidelity assessment of supported employment providers (from 2004 through the present), collection and analysis of data regarding provider

referral patterns for supported employment services (from October 2007 through the present), and quarterly claims audits conducted by the Office of Accountability (starting in October 2008 for services rendered in fiscal year 2008 and forward). (Baron Decl. ¶ 22.) As the court monitor has found, actual referrals "compare very favorably to past periods." (July 2009 Court Monitor Report at 31).

Because DMH has met the numerical threshold of this exit criterion, it should be vacated. Even if the Court modifies this exit criterion to require that DMH verify provider referrals of all eligible consumers, as the court monitor would prefer, the exit criterion should still be vacated because substantial compliance has been achieved.

Exit Criterion 11—assertive community treatment

The parties agreed that this criterion requires DMH to demonstrate that it provides ACT to adults with serious mental illness. (*See* Consent Order, appended Exit Criteria at 6-7.) As discussed *supra* at 15-16, the goal of ACT is to provide more intensive services to treatment-resistant consumers who are at the greatest risk for re-hospitalization. It defies logic—particularly in light of *Horne*—that the District can be simultaneously a leader in commitment to and implementation of its ACT program *and* subject to court supervision for failure to provide community-based treatment. As one of only seven (7) jurisdictions to have state-wide programs, and with access increasing steadily, it is clear that the District has substantially complied with this criterion.

Exit Criterion 17(a)—continuity of care (adults)

Exit Criterion 17 requires that 80% of individuals discharged from inpatient psychiatric hospitalization receive non-emergency community-based services within seven days. (*See* Consent Order, appended Exit Criteria at 8.) This requirement

substantially exceeds national benchmarks. As reported by the National Committee for Quality Assurance ("NCQA") for 2008, the District is tied with New York as the highest performing state, with a rate of 54.4%. (*See* Berhow Decl. ¶ 5; July 2009 Court Monitor Report at 13 (noting a rate of 54.17% for fiscal year 2008).) Thus, exit criterion 17(a) requires the District to exceed the national "best" by roughly 25 percentage points, a requirement clearly prohibited by *Horne*. *See Horne*, 129 S. Ct. at 2595 (prohibiting requirements "aimed at eliminating a condition that does *not* violate federal law or does not flow from such a violation") (emphasis added) (internal quotation marks and brackets omitted).

Exhibit 8
Supported Employment Policy

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Evidence Based Supported Employment Services**		
POLICY NUMBER **DMH Policy 508.1**	DATE MAR 2 2 2005	TL# 65

Purpose. To ensure that all consumers specified below have access to supported employment services.

Applicability. Applies to DMH enrolled consumers eighteen (18) years of age and over with serious mental illness (SMI) or serious emotional disturbance (SED), as applicable; DMH-certified CSAs; subproviders; specialty providers; supported employment providers; and the Mental Health Authority (MHA).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

*If any CMHS or DMH policies are referenced in this policy, copies may be obtained from the DMH Policy Support Division by calling (202) 673-7757.

ACTION

REMOVE AND DESTROY	INSERT
None	**DMH Policy 508.1**

Martha B. Knisley
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 508.1	Date MAR 2 2 2005	Page 1
	Supersedes: None		

Subject: Evidence Based Supported Employment Services

1. **Purpose**. To ensure that all consumers specified below have access to supported employment services.

2. **Applicability**. Applies to DMH enrolled consumers eighteen (18) years of age and over with serious mental illness (SMI) or serious emotional disturbance (SED), as applicable; DMH-certified CSA's; subproviders; specialty providers; supported employment providers; and the Mental Health Authority (MHA).

3. **Authority**. Mental Health Service Delivery Reform Act of 2001; Final Court Ordered Plan, dated April 2, 2001; and the Dixon Court Ordered Exit Criteria, dated December 12, 2003.

4. **Background**. Evidence-based supported employment is designed for consumers with the most significant disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a significant disability.

Evidence-based supported employment involves community-based employment in integrated work settings that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the consumer.

5. **Definitions**.

5a. Supported Employment. A part-time or full-time job in which a consumer receives supports in a competitive employment setting and in which the consumer earns at least the minimum wage. Supports shall include on-going work-based vocational assessments, job development, job placement, job coaching, crisis intervention, development of natural supports and follow up for each consumer including offering job options that are diverse and permanent.

5b. Individual Placement and Support (IPS) Model. This model incorporates a standardization of supported employment principles, so that evidence-based supported employment can be clearly described, scientifically studied, and implemented. There are six (6) core principles of the evidence-based IPS model of supported employment: (1) competitive employment is the goal; (2) supported employment is integrated with mental health treatment; (3) eligibility is based on the consumer's choice; (4) consumer preferences are important; (5) job search starts soon after a consumer expresses interest in working; and (6) follow-along supports are continuous.

5c. Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) – Persons with SMI or SED as defined in DMH Priority Populations Rule, Title 22A DCMR, Chapter 12.

6. **Policy**.

6a. DMH is committed to promoting evidence-based supported employment services based on the interests and preferences, as well as career goals, of consumers 18 years of age and over with SMI or SED.

6b. All enrolled consumers 18 years of age and over with SMI or SED who request a referral for supported employment shall be referred to an authorized supported employment provider and accepted into services within thirty (30) days of the request.

6c. Authorized supported employment providers must design and implement supported employment services based on the IPS model for supported employment, which is an evidence-based practice, as well as refer consumers who are receiving supported employment services to the District of Columbia Rehabilitation Services Administration (RSA) for additional assistance in order to maximize employment services.

6d Evidence-based supported employment services shall be authorized and provided in accordance with the consumer's treatment plan. The treatment plan shall document the consumer's employment interests and career goals.

6e. The consumer employment and career planning process must be driven by the consumer's preferences, and not by provider expectations or decisions.

6f. Supported employment providers shall have the capacity to provide the services consistent with the consumer's treatment plan, and shall involve employment specialists in the development of the treatment plan.

7. **Responsibilities and Procedures**.

7a. CSAs, subproviders and specialty providers shall:

(1) **Refer** any consumer 18 years of age and over with SMI or SED who requests assistance with obtaining employment to a supported employment provider within three (3) days of that request.

(2) **Inform** any consumer 18 years of age and over with SMI or SED who requests assistance with obtaining employment of all available supported employment providers and allow the consumer to select the agency of their choice.

7b. Supported Employment Providers (CSAs that DMH has contracted with to provide evidence-based supported employment services) shall provide the following services:

(1) Supported Employment Intake and Referral to Rehabilitation Services Administration (RSA) – Involves interviews, resume development, meetings, and activities related to consumers entering the supported employment program to obtain community-based employment. Activities related to helping consumers obtain services from the RSA, once the consumer is enrolled in supported employment are also covered through the intake and referral process.

(2) Assessment and Vocational Profile Development – Involves use of environmental assessments and consideration of reasonable accommodations along with development of vocational profiles conducted in partnership with consumers. Core components of assessments should include consumer employment goals, interests, preferences, and abilities, along with employment/academic history. Minimal testing may occur but not as a requirement for receiving supported employment services.

(3) Benefits Counseling – Includes, but is not limited to, helping consumers examine and understand how work may impact benefits received such as supplemental security income (SSI), social security disability income (SSDI), medical assistance and other disability related benefits. May also involve advocacy on behalf of consumers to resolve problems related to their benefits.

(4) Treatment Team Coordination – Involves coordination and contact with treatment team members regarding the provision of supported employment services to consumers. Contact may consist of, but is not limited to, meetings, one-to-one calls, conference calls, and electronic communication such as email and fax.

(5) Community Marketing and Job Development – Marketing and job development involves helping consumers with activities that lead to community-based competitive jobs based on consumer preferences. Activities can involve, but are not limited to, resume development, completing job applications, direct or indirect contact with employers, business groups, chambers of commerce, as well as networking events, job fairs and other opportunities, which result in jobs for consumers.

(6) Job Coaching – Supports provided to consumers that may involve, but are not limited to travel, training, money management, job appropriate grooming and hygiene, problem resolution, on-the-job training, interpersonal skills development, and overall adjustment to a work environment. Job coaching can be provided off-site as well as on-site if the consumer prefers, or chooses not to disclose their disability to the employer.

(7) Follow-Along Supports – Supports provided to consumers and their employers that are time-unlimited. Consumer supports can involve, but are not limited to, crisis intervention, career counseling, job coaching, treatment changes, travel, training, and job support groups. Employer supports may include, but are not limited to, staff training, disability awareness education, and guidance.

7c. Employment Specialists, who work for Supported Employment Providers, shall:

(1) **Manage** a supported employment caseload of 15 to 25 consumers.

(2) **Demonstrate** the ability to identify consumer interests, preferences, and abilities and then help the consumer obtain employment of their choice.

(3) **Demonstrate** the ability to advocate for consumers.

(4) **Possess** basic knowledge of community marketing and job development.

(5) **Demonstrate** the ability to identify as well as arrange/provide job coaching and long-term supports to help consumers maintain employment.

(6) **Demonstrate** the ability to liaison with the Rehabilitation Services Administration (RSA) counselors in order to assist consumers in obtaining community-based employment.

7d. The Mental Health Authority (MHA) Office of Programs and Policy (OPP) shall:

(1) **Provide** training, support, and tools for implementing the Individual Placement and Support (IPS) model.

(2) **Conduct** a baseline evaluation using the supported employment fidelity scale within one (1) month of the provider's supported employment program start-up, with a second evaluation conducted six (6) months after program start-up. An annual fidelity evaluation will be conducted thereafter.

(3) **Require** supported employment providers receiving a fidelity score below 55 to develop a plan of correction and receive technical assistance from MHA Employment Specialist. If the supported employment program's score does not improve to 55 or higher, a determination regarding continuation of funding will be made.

(4) **Collect** supported employment outcome information on a monthly basis from supported employment providers. Core outcome data to be collected involves number of consumers served, number of consumers employed, number of consumers referred to the RSA, hours worked, wages earned, types of jobs held by consumers, and number of consumers participating in education programs.

(5) **Utilize** quality improvement information from a variety of sources, including but not limited to, consumer satisfaction surveys, community services review results, and routine oversight and monitoring activities, in order to monitor consumer satisfaction with supported employment services.

8. **Mandatory Monthly Meetings**. Managers of supported employment programs and employment specialists must attend monthly mandatory meetings to be held by the MHA Employment Specialist.

9. **Inquiries**. Questions related to this policy should be addressed to the MHA, Office of Programs and Policy (OPP), Supported Employment Specialist at (202) 671-2985.

10. **Related References**.
DMH Priority Populations Rule, Title 22A DCMR, Chapter 12
DMH (MHRS) Provider Manual

Approved By:

Martha B. Knisley
Director, DMH

Martha B. Knisley 3/22/05
(Signature) (Date)

Exhibit 9
Proposed Order

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Civil Action No. 74-285 (TFH)
	)	
ADRIAN M. FENTY, et al.,	)	
	)	
Defendants.	)	
_____	)	

[PROPOSED] ORDER

Upon consideration of Defendants' Motion to Vacate December 12, 2003 Consent Order and to Dismiss Action, any response thereto, and the entire record in this matter, it is hereby **ORDERED** that Defendants' Motion is **GRANTED**, the December 12, 2003 Consent Order and all other Orders currently in effect in this matter are **VACATED**, and this case is **DISMISSED**.

SO ORDERED.

Dated: _____

_____
Hon. Thomas F. Hogan
United States District Judge