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

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF ARKANSAS *et al.*; Defendants.	)	CIVIL ACTION NO: 4:09-CV-33-JLH

UNITED STATES' POST-TRIAL BRIEF

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The Conway Human Development Center ("CHDC") is an institution geared toward the life-long institutionalization of people with intellectual and developmental disabilities. Defendants segregate people in CHDC and restrict their ability to fully and independently participate in life in violation of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101-12213. Moreover, Defendants expose people confined in CHDC to harmful, dangerous conditions, including preventable injuries and death, unnecessary and prolonged bodily restraint, and substandard care and treatment in violation of the Fourteenth Amendment. Additionally, Defendants deny children in CHDC adequate special education services in violation of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400-1482. As a result, people in CHDC suffer serious harm and death; children are deprived of the education services to which they are entitled; and individuals are denied any real opportunity to ever leave CHDC.

Defendants Deny People Confined to CHDC a Meaningful Opportunity To Live in the Community in Violation of the ADA

The ADA mandates that Defendants offer services to people with disabilities in the most integrated setting appropriate to their needs. *See generally Olmstead v. L.C.*, 527 U.S. 581 (1999). It is impossible to determine what type of setting is appropriate without conducting an objective, reasonable assessment. CHDC fails to even attempt to assess people confined there and identify the specific services necessary to meet their needs unless a guardian affirmatively requests or expresses interest in community placement. Even when CHDC conducts an assessment, staff members are too ill-informed about what community services are available in Arkansas, and what skills an individual needs to be eligible for a community program, to provide an independent, reasonable determination about the most integrated setting appropriate for an

individual. CHDC treatment plans demonstrate staff members' lack of knowledge about community programs and reveal CHDC's discriminatory bias in favor of continued institutionalization.

Both people in the facility and their guardians are ill-served by CHDC's failure to provide objective, reasonable assessments. Guardians, deprived of the knowledge that a placement tailored to the individual needs and strengths of their loved ones may exist, naturally are inclined to maintain the *status quo* of continued institutionalization. Defendants' failure to provide objective, reasonable assessments perpetuates this discriminatory system and dooms people to lifelong confinement at CHDC.

Defendants Expose People Confined to CHDC to Serious and Preventable Harm in Violation of the Fourteenth Amendment

Defendants also routinely expose people confined to CHDC to serious, preventable harms in violation of the Fourteenth Amendment's Due Process Clause. *See generally Youngberg v. Romeo*, 457 U.S. 307 (1982). At CHDC, there are disturbing patterns of staff abuse/neglect, preventable self-injurious behaviors, inappropriate and excessive use of restraints, and serious injuries such as fractures and lacerations from falls and other preventable incidents. Many of the harmful conditions are the by-products of institutionalization and could be prevented with adequate information and planning. Aspiration pneumonias, choking, bone fractures, and skin pressure ulcers from inadequate physical and nutritional supports, and injuries from unaddressed challenging behaviors, are all highly preventable with timely assessments of individuals that drive appropriate interventions and ongoing monitoring. CHDC's failure to engage in meaningful, individualized assessments and monitor their implementation results in serious injuries and other harm.

CHDC also excessively relies on physical restraints, and uses archaic forms of restraint, as the first response to behavior rather than as a last resort, in violation of the Constitution. Little is done to determine the cause of the behaviors that purportedly justify the restraint, nor is an effort made to determine what behavioral interventions might be appropriate, whether staff are implementing behavioral interventions correctly, or whether a change in behavioral interventions would render restraint unnecessary. Once again, Defendants' failure to properly assess the psychological needs of individuals with challenging behaviors, and provide treatment accordingly, exposes people to ineffective behavioral interventions and prolonged, harmful, and unnecessary bodily restraint in violation of the Fourteenth Amendment.

Likewise, CHDC's failure to properly prescribe and monitor the side effects of psychotropic medications causes significant, even fatal, harm. Although CHDC administers powerful psychotropic medications to hundreds of people confined to CHDC, the facility lacks a coherent system for identifying and assessing side effects.

CHDC's assessments of psychiatric illnesses are glaringly deficient. Far too often, the prescription of powerful medications is based solely on the recommendation of unqualified staff without an appropriate psychiatric diagnosis. People in CHDC are often needlessly exposed to serious harm caused by unmonitored psychotropic medication side effects, deficient assessments of medication efficacy, untimely psychiatric assessments and follow up care, and inadequate oversight of CHDC's untrained, over-stretched psychiatrist – who inappropriately delegates critical determinations to unqualified, nonmedical, staff. CHDC also exposes people to serious harm from inappropriate use of medication to suppress other medication's side effects, to respond to non-psychiatric environmental behaviors, and to chemically restrain individuals.

CHDC's general medical services rely on untrained direct care staff to identify health problems. CHDC's medical staff is unqualified and poorly supervised. This substandard medical care system explains why people confined to CHDC die an average of 25 years earlier than residents at comparable state facilities.

People in CHDC are also exposed to preventable harm and death from Defendants' failure to adequately manage physical and nutritional needs in violation of the Fourteenth Amendment. Many people in CHDC die of preventable aspiration pneumonia or other respiratory-related causes. Staff implementing physical and nutritional management plans, necessary to prevent choking and aspiration, do not monitor or provide support consistent with the level of risk. Consequently, Defendants needlessly expose individuals who are at high risk of aspiration and choking to severe harm, including death. Similarly, CHDC fails to properly reassess risk and implement physical management positioning plans. Far too often, people in CHDC suffer from repeated bone fractures or skin pressure sores.

Defendants Deny CHDC Children Their Right to Education in Violation of the IDEA

Children confined to CHDC are entitled, under the IDEA, to an education in the least restrictive environment and to related services that enable them to benefit from that education. CHDC fails to meet this mandate. Defendants violate the IDEA's requirement of a free and appropriate public education ("FAPE") by failing to provide special education, related and transition services reasonably calculated to enable students to receive educational benefits. Specifically, Defendants fail to provide students an education in the least restrictive environment; fail to provide adequate instructional time, required related services (*e.g.*, communication, audiology, and psychology services), and adequate transition planning; fail to

target skill development to allow progress toward more integrated settings; and employ untrained and unsupervised education staff. Indeed, even Arkansas's own Department of Education concluded that CHDC's education services violate the IDEA.

Defendants also fail to comply with the IDEA's procedural requirements. For example, Defendants fail to offer CHDC students a full continuum of educational placements in violation of the IDEA. Additionally, neither a Local Education Agency ("LEA") representative nor a regular education teacher routinely attend individualized education plan ("IEP") meetings; IEPs do not contain mandatory appropriate, measurable goals and objectives; IEP teams fail to consider IDEA-required factors for developing IEPs; CHDC students do not receive regular or alternate statewide or districtwide assessments; and CHDC routinely fails to invite agency representatives to assist students in transitioning to postsecondary services, all of which are required under the IDEA.

* * *

The people confined to CHDC range in age from 7 to 70, and have diverse diagnoses, interests, capacities, and needs. Defendants cannot ensure their safety, nor adequately protect their rights, without meaningfully assessing how to do so. Defendants' failure to conduct individualized, comprehensive, independent assessments, and provide care and services accordingly, subjects individuals to unnecessary and serious risk of harm, results in substandard medical care, denies children required education services, and preserves a discriminatory, institutionally-biased, and unlawful system in violation of the Constitution and federal law.

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I. INTRODUCTORY FINDINGS OF FACT

1. The Conway Human Development Center ("CHDC") serves more than 500 residents with intellectual and developmental disabilities who range in age from 7 to 70. Richardson Tr. 533:3-15; US Ex. 229 (CHDC Statistical Summary). The population of the CHDC facility has remained static during the last few years. J.C. Green Tr. 763:21-764:2. CHDC is licensed to serve 539 individuals. US Ex. 229.

2. CHDC is an institution within the meaning of 42 U.S.C. § 1997. Answer and Affirmative Defenses # 14 [Dkt. 4].

3. CHDC is the oldest and largest of Arkansas's six human development centers ("HDCs"). J.C. Green Tr. 764:3-9. It is located on 409 acres of land bordering Interstate 40 in Conway, Arkansas. Defendants' Response to Plaintiff's Statement of Undisputed Facts at 2 [Dkt. 104]. CHDC was originally called the Arkansas Children's Colony, and is the only Arkansas HDC housing children. J.C. Green Tr. 764:7-765:1.

4. The State, through the Division of Developmental Disabilities ("DDS") of the Arkansas Department of Human Services ("DHS"), coordinates services for individuals with intellectual and developmental disabilities and provides congregate services for individuals at the HDCs, including CHDC. J.C. Green Tr. 748:23-749:2; Defendants' Response to Plaintiff's Statement of Undisputed Facts at 2 [Dkt. 104]. The Director of DHS reports to the Governor of Arkansas. J.C. Green Tr. 749:17:750:1.

5. Dr. James C. Green, as the DDS Commissioner, is responsible for overseeing the operations of the HDCs, including CHDC. J.C. Green Tr. 749:17-750:9. He also oversees the

administration of Arkansas's Alternative Community Services ("ACS") waiver program. J.C. Green Tr. 749:3-16; Cromer Tr. 1411:22-1412:5.

6. Calvin Price is the superintendent of CHDC. He oversees all administrative operations at CHDC, including – but not limited to – staffing decisions, budgetary matters, performance reviews, and supervision of team leaders, department heads, and some support staff. Price Tr. 1656:3-12, 6864:14-25. He makes the final decision on all admissions to and discharges from CHDC, defines how CHDC reviews clients' restraint use and incident investigations, serves as CHDC's official representative to state agencies and the community, and administratively reviews all safety plans, positive behavior support plans, and incident investigations. Price Tr. 1690:14-19, 1669:16-1670:12, 6867:22-6868:17, 1656:6-12, 6872:25-6874:21, 6877:12-14. As superintendent, he describes himself as having "administrative oversight of the human development center 24 hours a day, seven days a week." Price Tr. 6863:21-22.

7. The State officials who operate or control CHDC have responsibility for the operation of CHDC and for the health and safety of the persons residing at CHDC. Answer and Affirmative Defenses # 13 [Dkt. 4].

8. The State officials who operate or control CHDC have obligations under the ADA and the IDEA regarding CHDC residents. Answer and Affirmative Defenses ## 16-17 [Dkt. 4].

9. The State officials who operate or control CHDC act under color of state law in providing care and services to individuals who reside at CHDC. Answer and Affirmative Defenses # 18 [Dkt. 4].

10. Individuals who receive services at CHDC have intellectual and developmental disabilities that require treatment, support, and services. Answer and Affirmative Defenses # 19 [Dkt. 4].

II. FINDINGS OF FACT – AMERICANS WITH DISABILITIES ACT

11. The Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101-12213, requires Defendants to offer services to individuals with disabilities in the most integrated setting appropriate to their needs. *See generally Olmstead v. L.C.*, 527 U.S. 581 (1999). Defendants are discriminating against individuals at CHDC by failing to ensure that they are served in the most integrated setting appropriate to their needs, in violation of the ADA. *Id.* at 602.

12. Specifically, CHDC treatment professionals fail to make objective, reasonable assessments based on the individuals' needs and services necessary to meet those needs, of whether individuals at CHDC could be served in a more integrated setting. Instead, CHDC simply determines all CHDC residents are not appropriate for placement in a more integrated setting, unless and until the family seeks community placement. As a result, residents and their guardians are deprived of a treating professional's independent, individualized recommendation about whether the individual could handle or benefit from community placement. Without the benefit of an independent, reasonable assessment based on the individual's needs, including the opportunity to meaningfully discuss what services and supports the individual would receive in the community, guardians are inclined to maintain the *status quo* of continued institutionalization and segregation even when a more integrated setting may be available and appropriate for the individual. Moreover, without information about the specific needs of CHDC's population, providers of community services are unable to develop capacity and tailor the services they provide to the needs of those currently institutionalized. In this way, CHDC's failure to provide objective, reasonable assessments preserves CHDC's archaic and discriminatory system for providing services to individuals with developmental disabilities, and deprives individuals of

"equality of opportunity, full participation, independent living, and economic self-sufficiency," in violation of the ADA. 42 U.S.C. § 12101(a)(2).

13. The evidence of CHDC's failure to provide objective, reasonable assessments, and the resulting inability of guardians to meaningfully make placement decisions, is substantial. For example, CHDC treatment teams and guardians of residents testified that teams do not discuss or pursue specific placement options unless the family first requests such action. Tellingly, the only four individuals that CHDC treatment teams determined could be served in a more integrated setting were the very four individuals whose guardians had requested community placement.

14. Moreover, CHDC treating professionals do not have the information and knowledge necessary to make objective, reasonable assessments about whether individuals could be served in more integrated settings. CHDC staff members are so lacking in even the most basic understanding of the services available in the community that they are incapable of conducting reasonable assessments. Treatment team leaders admit they have very little, if any, knowledge about how individuals with developmental disabilities are served in the community or the benefits of community care, and several of the team leaders have never even visited a community placement. Their lack of knowledge is evidenced in CHDC transition plans that repeatedly list the same barriers to placement in a more integrated setting, such as skills acquisition, behavioral improvement, and medical needs, when, in fact, community programs that currently exist in Arkansas provide all of these services. CHDC treatment plans are generic, boilerplate, and reveal CHDC's discriminatory bias toward continued institutionalization. Few residents are ever discharged from CHDC. In fact, more people die at CHDC than get discharged.

15. The evidence of the impact of CHDC treatment teams' failure to make objective, reasonable assessments of the most integrated setting appropriate based on individuals' needs is

also significant. Guardians are not provided the information necessary to meaningfully consider a more integrated setting. Staff and guardians consistently describe the treatment team process as little more than inquiring whether guardians are "happy" with CHDC or whether they are "interested" in community placement. In fact, guardians are asked to choose between community placement and continued institutionalization before they even meet with their loved ones' treatment team. CHDC treatment teams take no further steps if a guardian states they are happy in CHDC or not interested in community placement. Not only do CHDC treatment teams deprive families of information by not providing them with an independent recommendation, but they take no steps to ensure that families are informed about community options. Without specific, accurate information about what exists in the community and the options available to meet the needs of their loved ones, guardians cannot meaningfully make a decision about a more integrated placement, and Defendants preserve their discriminatory and unlawful system. 42 U.S.C. §§ 12101-12213.

A. CHDC Is a Segregated, Institutional Setting That Deprives Its Residents of the Opportunity To Fully and Independently Participate in Life.

16. CHDC is not an integrated setting but rather a self-contained facility. Richardson Tr. 541:10-14, 623:3-19; A. Green Tr. 830:10-831:21.

17. There are very few opportunities for CHDC residents to interact with non-disabled peers or develop friendships with non-disabled peers. Richardson Tr. 541:10-14; US Ex. 230 (Off Grounds Outing). CHDC residents receive most of their services on the facility grounds. Richardson Tr. 535:6-18; A. Green Tr. 831:1-6 (medical care and dental care is provided to residents at CHDC).

18. The off-campus outings available at CHDC are mostly large group activities such as going to the movies, and are offered to only a very small percentage of CHDC residents. Richardson Tr. 535:19-537:6; US Ex. 230 (Off Grounds Outing for May 2009). Such activities do not provide CHDC residents with an opportunity to meaningfully interact with or get to know non-disabled peers on a more personal level. Richardson Tr. 535:19-537:6

19. Virtually no one spends their day outside of CHDC. Currently, no CHDC residents participate in day programs outside of facility grounds. Richardson Tr. 537:9-16; US Ex. 229. Only 11 individual CHDC residents work off-campus – a mere two percent of the individuals at CHDC. Richardson Tr. 533:19-534:17; US Ex. 229.

20. The overwhelming majority of the CHDC residents sleep in dormitories that deprive individuals of the privacy, personal space, and security for belongings that adults typically enjoy. Richardson Tr. 537:17-540:14 ("[W]e don't tend to share our sleeping spaces with multiple people. Even folks who go to a nursing home don't want to sleep in a more than two-person room, and most don't want to do that either. So it's the norm for our society is to have your own sleeping space and your own place to have your belongings."), 543:7-23; US Ex. 235.

21. In some CHDC residences, as many as ten individuals sleep in one room. Price Tr. 1679:23-1680:6. Other residences have four individuals or more to a room or segment. Richardson Tr. 537:17-538:14.

22. CHDC residents do not "have a daily opportunity to participate in what's for most of us a fairly normal activity of preparing a meal, and being around a meal when a meal is being prepared." Richardson Tr. 540:24-541:9. Instead, food for CHDC residents is "pre-prepared" in a central kitchen and then is transported out to the units for meals. Richardson Tr. 540:24-541:9; A. Green Tr. 830:10-19.

B. The Arkansas System for Serving Individuals With Developmental Disabilities Promotes Institutionalization.

1) CHDC Residents Tend To Enter CHDC As a Child and Stay for a Lifetime.

23. Most current residents of CHDC entered the facility as children or youth. US Ex. 454. More than one-third of the current CHDC residents were admitted to the facility when they were younger than 10 years of age, and 82 percent of residents were admitted when they were under 18 years of age. US Ex. 454.

24. Of the 419 residents who entered CHDC under the age of 18, 62 percent (more than half of CHDC's population) have been there for 30 years or more. US Ex. 454 at 2-3.

25. For example, ME was admitted to CHDC in 1968, when he was just 6 years old. US Ex. 160. He spent over 40 years at CHDC – the remainder of his life. ME died of aspiration pneumonia in 2009. Price Tr. 6883:21-6884:5; Weaver Tr. 378:25-379:3.

26. JR is now a 46-year-old man, but he was just 6 years old when he was admitted to CHDC over 40 years ago, in 1970. US Ex. 140-1 (Redacted Individual Program Plan ("IPP")).[1] Although JR is able to walk, talk, follow directions, dress and feed himself, and operate a shredding machine, every indication from his IPP is that JR, who has not seen his guardian in over 30 years, will remain at CHDC for the rest of his life. The long range goal in JR's IPP states, "[b]y 2012 I will have self-care and daily living skills enabling me to function more independently in my present residence." US Ex. 140-1 at CON-US-0322156.

27. ZS is still a child, just 12 years old. US Ex. 206. He, too, was 8 years old at the time of his admission to CHDC in 2007. ZS's admission to CHDC was supposed to be a temporary

[1] US Ex. 466 includes a spreadsheet of names for the redacted IPPs.

placement while waiver services were set up for him. US Ex. AG-1; A. Green Tr. 6802:21-25. Yet, at the time of trial, ZS was still living at CHDC and his IPP reflects no expectation that ZS will ever leave CHDC. His long range goal states, "By 2012, I will learn appropriate behaviors in order to function more independently in his [sic] environment at CHDC and home visits." US Ex. 206 at CON-US-0110256.

28. Indeed, few admitted individuals are ever discharged from CHDC, and even fewer individuals are discharged to more integrated settings. Richardson Tr. 541:24-542:16; US Ex. 271. Since July 2009, only 6 admitted individuals were discharged from CHDC. A. Green Tr. 6768:8-12. Only 18 individuals were discharged between June 2007 and July 2009. US Ex. 271; Richardson Tr. 541:15-542:16. Seven of those individuals were placed at other Arkansas human development centers. US Ex. 271. Only 11 people during that two year period – slightly more than 2 percent of the population – were discharged into more integrated settings, such as their family home or placements run by private community-based service providers. US Ex. 271.

29. In 2006 and 2007 an individual was more likely to die at CHDC than be discharged. US Ex. AG-2; A. Green Tr. 6794:4-6795:13.

30. In fiscal year 2008/2009, CHDC's goal was to discharge 4 residents. US Ex. 235 (CHDC Belief-Based Performance Management and Strategic Plan: Outcome 1). CHDC's original discharge goal had been eight, but was reduced to four because CHDC had been unsuccessful at reducing its population the previous year when admissions exceeded discharges. G. Miller Tr. 5041:13-5044:5; US Ex. GM-2.

31. In the last two years, CHDC has admitted more children than adults. A. Green Tr. 846:18-22; C. Price 1690:17-23.

32. There are approximately 50 school-aged individuals (under 21 years of age) living at CHDC, making up approximately 10 percent of the population at CHDC. US Ex. 229; J.C. Green Tr. 764:20-765:1; A. Green Tr. 846:2-5.

33. CHDC has expanded its capacity for housing children since 2003. J.C. Green Tr. 768:3-6. Prior to the announced closing of Alexander HDC in Spring 2010, DDS had planned to expand CHDC's capacity for school-aged children to approximately 75. J.C. Green Tr. 765:24-768:6; Price Tr. 1690:24-1692:20; US Ex. 1105 at 10.

34. An institutional environment is not a normal environment for any child. Richardson Tr. 548:5-17. It denies the child opportunities to have contact with non-disabled peers and to have an ongoing parental relationship with an adult. Richardson Tr. 548:5-17.

35. Children who are institutionalized run the risk of remaining institutionalized for the rest of their lives. Richardson Tr. 548:18-549:3. Long term institutionalization makes it very difficult to separate children from that environment later in life. Richardson Tr. 548:18-549:3. As a result, children grow up without opportunities for more normal lives in which they could participate in the community or another less restrictive setting. Richardson Tr. 548:18-549:3.

36. In addition, institutionalization has long term consequences for children as they age, such as developing "institutional behaviors," which result when the children observe and model the other maladaptive behaviors that occur around them. Matson Tr. 1179:4-15; *see also* Matson 1312:9-1313:4 (children's development harmed by unsound medication practices).

37. Arkansas is exceptionally restrictive in its treatment of children with developmental disabilities. Matson Tr. 1098:1-7 (psychology expert Matson has never "seen any other residential facility with this many kids [living and] receiving all of their schooling on the campus"), Matson Tr. 1108:1-1109:16 (50 out of 50 students on shortened school day and lack

of integrated behavioral services); US Ex. 1216 (ADE monitoring file citing CHDC for various deficiencies).

2) The Arkansas System for Serving Individuals with Developmental Disabilities Relies Disproportionally on Institutionalization.

38. Arkansas serves more individuals with intellectual and developmental disabilities in institutions than any other state but Mississippi. US Ex. 212 & 212-2; Richardson Tr. 593:21-595:6. Per 100,000 people in the general state population, Arkansas serves 39 individuals in institutions. US Ex. 212-2; Richardson Tr. 593:21-595:6. The national average is 12.9. US Ex. 212-2.

39. Arkansas's system for delivering services to individuals with developmental disabilities "makes it easier for a person to enter an institution than receive services in the community." J.C. Green Tr. 792:22-793:8; US Ex. 232 at CON-US-0018017.

40. The State's Governor's Integrated Services Task Force Report admits that "[t]oo often, when a person experiences an acute illness, injury, or behavioral episode, entry into the institution is the initial solution. Once the person has made the necessary lifestyle changes to enter an institution, he or she may find it more difficult to return home than it would have been to remain in the community in the first place. Many supposed "short-term" stays in a nursing home or an Intermediary Care Facility for Mental Retardation ("ICF/MR") become extended stays that last a lifetime." US Ex. 232 at CON-US-0018017; J.C. Green Tr. 793:9-19.

41. According to data from 2007, many states do not use any large (defined as 16 or more beds) public facilities for individuals with developmental disabilities at all including West Virginia, New Mexico, Vermont, Rhode Island, New Hampshire, Alaska, Hawaii, Indiana, and Maine. Richardson Tr. 595:16-19; US Exs. 212, 212-2 & 214 at iii.

42. In addition, as of June 30, 2007, at least 7 additional states served 100 or fewer individuals with intellectual and developmental disabilities in large state-operated institutions: Delaware, Idaho, Minnesota, Montana, Nevada, Oregon, and Wyoming. US Ex. 214 at 21-32. In 2006, 7 more states served 230 or fewer individuals with intellectual and developmental disabilities in state-operated institutions: Alabama, Arizona, Colorado, Michigan, North Dakota, South Dakota, and Utah. US Ex. 212-2.

43. From 1990 to 2006, the number of individuals with developmental disabilities residing in large institutions nationwide declined 55 percent, from 84,818 individuals to 38,299 individuals. US Exs. 212 & 212-2 at 49. Since 1980, the average state reduced its use of ICF/MR institutions by 71.7 percent, while in this timeframe Arkansas has reduced its use of ICF/MRs by 31.2 percent – less than half that amount. US Ex. 214 at 7; Richardson Tr. 596:11-596:17.

44. Other states, such as Pennsylvania, have acknowledged that all of the individuals in the state's ICF/MRs can be served outside of institutions with appropriate supports. Richardson Tr. 597:20-25. New Hampshire provides services to individuals with developmental disabilities exclusively in community settings. US Ex. 212-2.

45. Arkansas ranks 44th for allocating resources to those individuals with developmental disabilities in the community, 49th for supporting individuals in community and homelike settings, 50th in keeping families together through family support, and 51st in supporting meaningful work. Kastner Tr. 4446:16-4449:19 (testimony of Defendants' consultant Dr. Theodore Kastner, conceding Arkansas's ranking in the United Cerebral Palsy, Inc.'s independent annual report "The Case for Inclusion," a report Dr. Kastner had cited in his previous work in Connecticut) (report surveys all 50 states and the District of Columbia).

46. The Arkansas ACS Waiver program is a part of the federal Home and Community-Based Services ("HCBS") program funded by the Centers for Medicare and Medicaid Services ("CMS"). US Ex. 254 (Application for a § Arkansas 1915(c) Home and Community-Based Waiver Application); *see* Richardson Tr. 627:16-628:22. The ACS program provides community-based services for individuals with developmental disabilities as an alternative to and to prevent institutionalization. Cromer Tr. 1410:21-1413:5.

47. Individuals who are eligible for an institutional level of care, have a developmental disability, and meet the Medicaid income eligibility requirements are eligible for participation in the waiver program. Cromer Tr. 1414:15-20.

48. The State gives people an incentive to enter the HDC system because people can get waiver services faster by first entering the HDCs and then applying for waiver services as a priority HDC resident. J.C. Green Tr. 780:3-783:18; Black Tr. 6838:6-16 ("The other problem with the Medicaid waiver is, at the time when we were moving him from Easter Seals, they were working on number one, and we were number 2,200 something.").

C. ADA Expert Toni Richardson Provided Credible Expert Testimony.

1) Expert Richardson Is Well-Qualified To Review the Process Used by CHDC Interdisciplinary Teams.

49. The U.S. Department of Justice asked Toni Richardson to review CHDC's process for determining whether residents of CHDC can be served in a more integrated setting. Richardson Tr. 515:18-21, 734:22-735:5; US Ex. 210-1.

50. Expert Richardson has been working for more than 40 years on behalf of individuals with intellectual and developmental disabilities. Richardson Tr. 516:22-24; US Ex. 210-1 (Resume of Toni Richardson). For the last 15 years, she has been a consultant to states such as Pennsylvania,

Tennessee, Louisiana, and New Jersey, regarding their services for individuals with developmental disabilities. Richardson Tr. 515:22-24; US Ex. 210-1. She assists states with developing their quality assurance plans, developing five-year plans, and improving their community services. Richardson Tr. 516:4-13.

51. In addition, expert Richardson's recent work includes the review of interdisciplinary team decisions about placement of individuals institutionalized at the Clover Bottom and Greene Valley Development Centers in Tennessee into more integrated settings. Richardson Tr. 516:4-17. Ms. Richardson's independent professional evaluation of the individual plans is then further reviewed by a district court's quality review panel which is comprised of professionals in the field of developmental disabilities. Richardson Tr. 736:21-737:13.

52. Expert Richardson has extensive experience administering and managing state systems that serve individuals with developmental disabilities. She was the commissioner of the Connecticut Department of Mental Retardation for five years and prior to that was the regional director for the state-operated developmental centers in Connecticut. Richardson Tr. 518:17-519:21. Richardson also worked for several years as the supervisor of the Connecticut state office that licenses and certifies public and private organizations that serve individuals with intellectual and developmental disabilities, including public and private ICF/MRs. Richardson Tr. 518:4-11.

53. Richardson has direct experience working in institutions. Richardson Tr. 516:25-517:21. She worked as a direct care staff person, a special education teacher and teacher's supervisor at a large ICF/MR in Connecticut. Richardson Tr. 517:10-18.

54. Richardson has a master's degree in special education and is currently certified, as well as a law degree. Richardson Tr. 517:22-518:3, 519:2-5.

2) Expert Richardson's Review of Community Integration Practices at CHDC Was Thorough and Considered Information Typically Used by Treating Professionals.

55. As part of her review of the community integration process at CHDC, expert Richardson toured the facility for approximately 2 weeks in July and September of 2009. Richardson Tr. 522:19-24. She visited approximately 20 residential units, as well as day programs and employment workshops on the CHDC grounds. Richardson Tr. 522:25-523:10.

56. Before and after these tours, expert Richardson reviewed a range of documentation, including both system-wide and facility policies and procedures, CHDC-related surveys and data, individual records and program plans, and sources of nationwide data regarding services for individuals with developmental disabilities. Richardson Tr. 526:6-18, 527:6-12.

57. Expert Richardson interviewed key individuals on the CHDC staff including the director of social services, the five team leaders, and a representative from the Division of Developmental Disabilities Services. Richardson Tr. 523:7-10, 525:20-526:2.

58. Expert Richardson visited several providers of community-based services for individuals with intellectual and developmental disabilities. Richardson Tr. 523:17-25. These included two providers in the Conway area and three providers in the Little Rock area. Richardson Tr. 524:19-525:2. These visits included opportunities to observe apartment settings as well as smaller ICF/MRs that must adhere to the same rules and regulations that apply to CHDC. Richardson Tr. 524:19-525:2, 574:22-576:14. She was able to speak to the directors and staff members of these programs. Richardson Tr. 589:17-590:4, 591:9-15.

59. Expert Richardson picked a sample of 40 CHDC residents, met or observed them, and examined their records, including their IPPs. Richardson Tr. 526:16-18, 528:1-10, 606:23-25. For these 40 individuals, Richardson examined the process through which CHDC determined

whether they could be served in a more integrated setting, as required by the ADA and CHDC's own policies. Richardson Tr. 526:6-25, 527:23-528:15, 530:16-531:19, 532:3-22.

60. As she looked at each individual's records, expert Richardson read the summaries of their assessments, and looked for any interest in community placement as well as any descriptions of the individuals or program planning that was inconsistent with placement in a restrictive environment like CHDC, such as a need for quiet, private space, or one-on-one attention in order to learn well. Richardson Tr. 552:6-15, 557:24-558:6.

61. Expert Richardson also considered individuals' medical and health conditions, stability, behavior, potential for progress, pattern of services, age, and the activities and programs that the individual enjoyed participating in, including whether or not there would be more opportunities for that activity in a more integrated setting. Richardson Tr. 564:7-565:10, 572:10-25.

62. These are the types of factors an interdisciplinary team considers in deciding whether an individual is in the most integrated setting appropriate to their needs. Richardson Tr. 572:22-25. These are also the types of factors expert Richardson uses when she reviews IPPs in her role as an evaluator for a district court's quality review panel. Richardson Tr. 573:1-4.

D. CHDC Treating Professionals Are Responsible for Assessing Whether CHDC Is the Most Integrated Setting Appropriate for a Residents' Needs.

Social work supervisor

63. Angela Green is a "licensed certified social worker" and "oversee[s] the Social Services department at CHDC." A. Green Tr. 816:24-817:11. She has worked at CHDC since 2000. A. Green Tr. 816:22-23. As the head of the social services department, Angela Green's duties include the "hiring, training, and supervising" of all twelve program specialists, or social services workers, at CHDC. A. Green Tr. 817:12-17.

64. Green is considered the most knowledgeable person at CHDC about community placement. A. Green Tr. 819:7-12; Price Tr. 1695:11-16.

65. The social service workers that Green supervises are "responsible for providing information to residents and guardians for residents on their caseload about community placement options." They are also responsible for helping residents and guardians transition into community placements. A. Green Tr. 819:23-820:10.

Team Leader

66. Each individual at CHDC is part of one of five residential "teams" which coordinate approximately with an individual resident's level of skill, independence and/or disability. Richardson Tr. 554:3-14. Individuals in the Total Care Team ("TCT") have the most significant disabilities at CHDC. Richardson Tr. 554:3-14. Individuals in the Habilitation and Training Team ("HTT") are the most independent and high functioning individuals at the facility. Richardson Tr. 554:3-14; R. Brewer Tr. 1474:13-16.

67. Each of the five teams has a residential services manager, who is also known as the "team leader." L. Brewer Tr. 1459:10-20; Richardson Tr. 525:9-19. Team leaders are responsible for supervising one of the five teams at CHDC. L. Brewer Tr. 1462:3-1463:18; US Ex. 279. Their duties include "reviewing, monitoring, and approving programs for developmentally disabled individuals." L. Brewer Tr. 1462:18:22; R. Brewer Tr. 1474:20-23; US Ex. 279 ("Job Summary"). This specifically includes the duty to "approve or disapprove individual program plans." L. Brewer Tr. 1462:23-1463:3; US Ex. 279 ("Job Duties and Responsibilities No. 3"). Team leaders review IPPs and attend annual reviews to ensure that residents' plans meet their needs. L. Brewer Tr. 1463:12-18.

68. Larry Brewer has been a CHDC staff member since 1973. L. Brewer Tr. 1459:7-9. He is the team leader of the Individual Assistance Team ("IAT"). L. Brewer Tr. 1459:10-12, 1460:10-15.

69. Rebecca Brewer has been a CHDC staff member since 1974 and is the current team leader of the HTT. R. Brewer Tr. 1472:25-1473:7, 1474:7-9. The majority of CHDC residents who transition to more integrated settings do so from the HTT. R. Brewer Tr. 1474:17-19.

70. Doug Hart has been a CHDC staff member since 2003 and is currently the team leader of the Sheltered Living Team ("SLT"). Hart Tr. 1925:7-9, 1926:9-14. Many of the older individuals at CHDC are part of the SLT. Hart Tr. 1926:22-1927:1.

Program coordinator

71. Program coordinators are responsible for coordinating services for a particular caseload of residents. Clendenin Tr. 1565:16-23; Murphy Tr. 435:8-436:1. They conduct annual reviews, hold special staffings, monitor the implementation of program plans, review program plans, and draft the interpretative summary on individuals' IPPs. Clendenin Tr. 1565: 19-23; Murphy Tr. 436:14-19.

72. Program coordinators head the annual IPP meetings, compile the different disciplines' reports for the development of IPPs, and monitor progress towards the IPP's goals. Weaver Tr. 302:2-304:7; Hart Tr. 1927:14-16; Murphy Tr. 436:14-437:22.

73. Program coordinators should "know the most about a resident's overall condition." L. Brewer Tr. 1463:8-11; R. Brewer Tr. 1475:2-9. This includes the individuals' IPPs, safety plans, strategies, and positive behavioral support plans. Clendenin Tr. 1567:15-1568:14.

E. Defendants Discriminate Against Individuals at CHDC by Depriving Them of Objective, Reasonable Assessments Regarding Whether They Are Appropriate for a More Integrated Setting.

74. CHDC interdisciplinary teams ("IDTs") fail to conduct objective, reasonable assessments of whether CHDC residents can be served in a more integrated setting. *See* FOF ## 91-298. Instead, CHDC treatment teams routinely find that CHDC is the most integrated setting unless and until a resident's guardian proactively requests community placement. *See* FOF ## 91-114.

1) In Determining the Most Integrated Setting Appropriate, Interdisciplinary Teams Must Conduct an Independent, Objective Assessment of Individuals' Needs and the Supports Necessary To Meet Those Needs.

i. HDC Residents Should Be in the Most Integrated Setting Appropriate to their Needs.

75. The policy statements of the American Association on Intellectual and Developmental Disabilities and the President's Committee on Intellectual and Developmental Disabilities state that individuals with intellectual and developmental disabilities should be served in the most integrated setting appropriate to their needs. Richardson Tr. 736:5-20, 737:14-17.

76. Similarly, the DDS mission statement commits DDS to "statewide planning that ensures optimal innovative growth of the Arkansas services to meet the needs of people with developmental disabilities and to assist such persons to achieve independence and integration into the community." Richardson Tr. 530:9-531:13; US Ex. 211.

77. The DDS mission also states its commitment to delivering services to individuals with developmental disabilities in the least restrictive environment appropriate for that individual person. Richardson Tr. 531:2-13; US Ex. 211.

78. CHDC's mission statement acknowledges that CHDC is "committed to utiliz[ing] the least restrictive alternatives to meet the developmental needs of individuals and foster a return to community living." Richardson Tr. 532:3-25; US Ex. 238.

79. Each individual admitted to CHDC should have an IPP. US Ex. 278 (CHDC Individual Program Plan policy). CHDC's Individual Program Plan policy states that the IPP is to be "goal-directed and must define the direction in which a person wants their life to go." US Ex. 278 at 1; Richardson Tr. 584:5-12; L. Brewer Tr. 1464:1-5; R. Brewer Tr. 1475:10-13. In doing so the IPP should "specify long-range goals, behavioral objectives, and service objectives." US Ex. 278 at 1; L. Brewer Tr. 1464:6-8.

80. CHDC interdisciplinary teams discuss the IPP annually at the annual review meeting. US Ex. 278 at 1. "The annual review is driven by the belief that throughout a lifetime, a person continues to develop increased competence/independence in successively less restrictive settings. It is the foundation for all decisions regarding services for any individual." US Ex. 278 at 2; L. Brewer Tr. 1464:9-13.

81. According to DDS policy, one of the purposes of the annual review meeting is to determine that resident's eligibility to *remain* at an HDC. Defs Ex. 912 at 107 (DDS Policy 1086: Human Development Center Admission and Discharge Rules) (emphasis added); *see also Porter v. Knickrehm*, 457 F.3d 794, 797 (8th Cir. 2005) (Court of Appeals affirmed the District Court's approval of the new HDC admission/discharge rules). DDS policy regarding Human Developmental Center admission states in part that "in order to be eligible for admission the individual must be eligible for developmental disabilities services, be in need of and able to benefit from active treatment, and be unable to access appropriate adequate developmental disabilities services in a less restrictive alternative. Defs Ex. 912 at 106-07; *see also* Price Tr.

1692:16-20 (admission process should determine if an individual is "unable to access services in a less restrictive environment").

82. Consistent with this, CHDC policy states that the concluding step of the annual review meeting is "the review of all goals/objectives to determine the least restrictive alternatives available to enable the individual resident to achieve his/her personal goals." US Ex. 278 at 3; *see* Clendenin Tr. 1583:20-1586:15 (the primary purpose of an individual's annual review is to develop a plan for increasing a resident's independence and transition into less restrictive environments).

ii. To Determine How the Individual Can Be Placed in the Most Integrated Setting Appropriate to Their Needs, Treating Professionals Must Independently Assess the Individual's Desires, Needs, and Services Necessary To Meet Their Needs.

83. In determining the most integrated setting appropriate for an individual, the treatment team must examine the individuals' needs, services necessary to meet those needs, and the individuals' desires. *See* FOF ## 79, 80, 82 (Requirements of CHDC Individual Program Plan Policy).

84. The treatment team must provide an objective, clinically-based recommendation as to the appropriateness of community placement in order for residents and guardians to make an informed decision. Richardson Tr. 617:22-618:6.

85. Defendants' consultant Kastner agrees that the interdisciplinary teams' decision regarding the most integrated setting appropriate for any CHDC resident should be separate from the decision of the resident or guardian about placement outside of the facility. Kastner Tr. 4586:20-25.

86. The availability of services should not be a bar to being recommended for community placement. Richardson Tr. 629:16-19; Walsh Tr. 6143:8-16.

87. Interdisciplinary teams should be collecting information about the individual – their abilities, interests, likes, dislikes, challenges – and crafting a program that allows that individual to get what they want to out of life. Richardson Tr. 582:15-583:4, 605:19-606:10. Such an assessment provides information that should be used to determine the most integrated setting appropriate for that individual and what sort of specific, specialized services that individual would require in a more integrated setting. Richardson Tr. 580:18-581:5, 585:4-11.

88. CHDC assessments should provide a description of what a resident actually needs to live in an integrated setting beyond a generic list of services. Richardson Tr. 529:2-9, 550:5-551:11. The plan should include specifics such as what type of specialized medical care or behavioral health intervention the individual would need, what kind of specialist would be required, or what type of transportation might be necessary (or how often). Richardson Tr. 550:5-551:11.

89. Community placement expert Richardson described what an individualized assessment contains as follows:

> [W]hat I was looking for was more of a description beyond the generic; What is it about medical care? Is there something about medical care that the person would need? Would he need to be close to a hospital, for example? Would he need to have a specialist, a neuro specialist? Would he need physical therapy? Would it need to be physical therapy in his residence or could he go to the physical therapist for service? If he were in the community, he'd need transportation, but what kind of transportation would he need? Would he need to be near a bus line? Would he need to have a car available at the house he was living? Would he need to have a special wheelchair van, or would he need an extra-special wheelchair van? Because some people go out and their wheelchairs are such that they don't fit in a regular wheelchair van. So would he need a special wheelchair van? Those are the kind of elements that I expected to see discussed in the plan so that you'd have a very clear picture of what kind of services this person could possibly get in a community setting, or would need to get in a community setting and very specific to him. Because what that does is allow you to really think about his services, but also to, when

> taken together with the plans of other people, to inform providers about the kind of services they might need to develop.

Richardson Tr. 550:14-551:11.

90. The resulting program plans should apply the information gathered in the plan to assist the team in understanding how the resident can move to an appropriate more integrated setting. Richardson Tr. 580:18-581:5; *see* FOF # 87.

2) CHDC Teams Fail To Find That Any Residents Can Be Served in More Integrated Settings Unless a Guardian Affirmatively Requests or Expresses Interest in Community Placement.

91. CHDC's own policies require that the treatment team annually determine an individual's eligibility to remain at CHDC, including that the individual is unable to access appropriate services in a less restrictive alternative. *See* FOF # 81 (DDS policy 1086); *see also* Richardson Tr. 617:22-618:6, US Ex. 278.

92. However, in practice, unless a guardian requests placement in a more integrated setting, CHDC interdisciplinary teams overwhelmingly conclude that CHDC is the least restrictive setting appropriate for each individual. Richardson Tr. 529:10-22; *see* FOF ## 115-176 (CHDC erroneously finds that CHDC is the least restrictive setting appropriate); Kastner Tr. 4586:20-25.

93. At the time of trial, there were only four individuals at CHDC who were recommended by their interdisciplinary team for participation in the ACS waiver program. Richardson Tr. 546:19-547:3; US Ex. 284-1. According to CHDC, there were also only four CHDC residents seeking participation in the Arkansas ACS waiver program. Richardson Tr. 547:4-13; US Ex. 305-1. The four individuals recommended by their teams for the waiver program are the same four individuals seeking participation in the waiver program. Richardson Tr. 547:4-13; A. Green Tr. 836:16-837:9; US Exs. 284-1 & 305-1.

94. In the discharge/transition section of almost every CHDC individual program plan, the IDT concludes that CHDC is the "least restrictive environment" for that person and simply claims the guardian's assent or lack of interest in a more integrated setting. *See* FOF # 97.

95. For example, ZS's 2008 IPP concludes that CHDC "is the least restrictive placement for [ZS]," and notes that "[ZS's] mother and father are pleased with [ZS's] placement." US Ex. 206. His IPP further states that ZS would need to "acquire the skills necessary to transition through the Team hierarchy at CHDC before he could successfully function in a community setting," US Ex. 206, even though his 2007 admission to CHDC was supposed to be a temporary placement while he waited for waiver services to be set up. US Ex. AG-1; A. Green Tr. 6802:21-25.

96. In another example, ET's IPP concludes that CHDC is the least restrictive environment appropriate for his needs, US Ex. 127 at 10, however, he was discharged from CHDC on July 15, 2009. US Ex. 269 at US-CON-B-0034853; Richardson Tr. 559:1-17.

97. The overwhelming majority of CHDC IPPs reach the same conclusion – that the guardian wants the resident to stay at CHDC (or "is happy with CHDC") and that CHDC is the least restrictive environment for each resident. US Exs. 105 at 9 (IPP for AN), 115 at 14 (IPP for CL), 122 at 10, 12 (IPP for DB), 124 at 11 (IPP for DG), 132 at 15 (IPP for HB), 134 at 12 (IPP for JN), 135 at 11 (IPP for JR), 138 at 14 (IPP at JM), 143 at 12 (IPP for JW), 149 at 11-12 (IPP for LR), 160 at 14-15 (IPP for ME), 161 at 15 (IPP for MF), 162 at 13 (IPP for MD), 166 at 10 (IPP for NP), 167 at 10-11 (IPP of OM), 173 at 10 (IPP for RC), 176 at 20 (IPP for RN), 178-2 at 10 (IPP for RW), 179 at 10 (IPP for RD), 191-2 at 18 (IPP for TC), 193 at 10 (IPP for TR),194 at 17 (IPP for TH), 199 at 11 (IPP for WF), 202-2 (IPP for WC), 206 at 15 (IPP for ZS), 561-21 (IPP for SA), 562-3 at 11 (IPP for MB), 563-34 (IPP for GB), 566-21 (IPP for DB), 578-40 at 9 (IPP for MS) & 579-15 at 12 (IPP for CW); *see also* US Exs. 101-1 at 15, 102-1 at 15, 103-1 at 16,

109-1 at 17, 111-1 at 15, 113-1 at 10-11, 114-1 at 10, 129-1 at 9, 136-1 at 14, 139-1 at 11, 140-1 at 9, 146-1 at 9, 152-1 at 9-10, 156-1 at 12-13, 157-1 at 12-13, 163-1 at 16, 165-1 at 12, 171-1 at 10, 172-1 at 14, 175-1 at 10, 177-1 at 14, 180-1 at 13, 192-1 at 12, 196-1 at 12, 198-1 at 11 & 200-1 at 11 (redacted IPPs).

98. CHDC staff confirmed, both to expert Richardson during her tour of CHDC and later at trial, that IDT teams generally do not assess or even discuss a resident's appropriateness for a more integrated placement unless the guardian first expresses an interest in community placement options. Richardson Tr. 555:3-556:7, 606:23-607:12; US FOF ## 99-105.

99. The head of CHDC social services, Angela Green, told expert Richardson that CHDC waited for parents to initiate the search for a more integrated placement. Richardson Tr. 555:3-12. According to Ms. Green, CHDC did so in order to avoid raising the hopes of families and individuals, if there is no realistic expectation that that placement could be made available. Richardson Tr. 555:3-12. At trial, Ms. Green denied using the term "false hope" in her conversation with expert Richardson. A. Green Tr. 6763:24-6764:4 ("I did not use that term with her.").

100. Consistent with her remarks to Ms. Richardson, Ms. Green testified at her deposition that when an IPP sets forth the skills a resident needs to acquire prior to being considered for a more integrated setting, what that really means is that "the individual or guardian has not specifically requested alternate placement." A. Green Tr. 836:2-15.

101. According to CHDC program coordinator Judy Weaver, at IPP meetings, staff discuss specific community services only after an individual's guardian expresses interest in community placement. Weaver Tr. 413:7-413:22.

102. Similarly, CHDC program coordinator Sarah Murphy agreed that CHDC interdisciplinary teams do not identify any particular providers who could meet the needs of a resident until a guardian expresses an interest in community placement. Murphy Tr. 502:22-503:8 ("the team always discusses the least restrictive setting and discusses other placement options generally, like the client going to the parents' home, like Medicaid waiver services, you know, it's general. When you get down to more specific options, then those would be pursued upon the client and/or guardian's desire"), 501:15-502:9.

103. Team leader Rebecca Brewer testified that "the process of determining the appropriate setting essentially involves asking the guardian if they're interesting [sic] in pursuing a community placement," and whether they are "happy with the placement, do they want to pursue placement elsewhere, where do they think their family member is – you know, the most appropriate placement for the person they're responsible for." R. Brewer Tr. 1475:24-1476:8.

104. CHDC parent, Alan Fortney, testified that the guardian makes the initial recommendation regarding community placement and that typically the other team members accept that the guardian knows what is best for the resident and agree with the guardian. Fortney Tr. 1487:2-20, 1489:6-1492:6, 1503:6-18.

105. CHDC's superintendent, Calvin Price, can recall only one time in his eight years at CHDC when an IDT initiated consideration of transferring an individual to a more integrated setting before a guardian requested community placement. Price Tr. 1706:14-22.

106. When originally questioned at trial, CHDC Director of Social Services, Angela Green, could not recall any instance when team members determined that a resident was appropriate for a more integrated setting without the guardian first agreeing. A. Green Tr. 837:14-21; *see* FOF ## 63-65 (responsibilities of social worker supervisor). However, Ms. Green later changed her

testimony and stated she could recall "about two" times when an IDT recommended a resident be placed in a more integrated setting even though the guardian did not first agree to such a recommendation. A. Green Tr. 854:17-856:16.

107. Larry Brewer is the CHDC team leader of IAT, one of the five teams at CHDC. L. Brewer Tr. 1459:10-15; 1460:10-15, *see* US FOF # 67 (responsibilities of CHDC team leaders). He testified that after all of the annual reviews he has attended and IPPs he has reviewed in over 35 years of working at CHDC, he is not aware of any instances "where CHDC staff have determined that a resident is appropriate for community placement even though the parent or guardian disagrees." L. Brewer Tr. 1464:19-1465:1.

108. When called by the United States to testify at trial, Rebecca Brewer, team leader for the HTT, confirmed her April 2010 deposition testimony that she could not recall any situation where an IDT recommended a resident for a more integrated setting in the absence of support for or interest in community placement by a guardian. R. Brewer Tr. 1476:9-1478:15, 6755:19-22.

109. When subsequently called to testify at trial by Defendants, Ms. Brewer changed her testimony to say she now recalled one time when the IDT recommended a resident for community placement despite the guardian's objection to moving the individual to a more integrated setting. R. Brewer Tr. 6729:3-13, 6755:11-6756:2. Nevertheless, Ms. Brewer acknowledged that it is rare that the team recommends community placement unless the guardian first agrees. R. Brewer Tr. 6729:14-16.

110. Doug Hart is the team leader of the SLT, Hart Tr. 1926:9-14, and testified that he has never been to an IPP review meeting where the IDT recommended a more integrated setting without the guardian's request or support. Hart Tr. 1930:8-14.

111. Judy Weaver is a CHDC program coordinator and has worked at CHDC since 1979. Weaver Tr. 301:1-6; *see* FOF ## 71-73 (responsibilities of CHDC program coordinators). In her two years as a program coordinator, Ms. Weaver cannot recall a single incident of the treatment team and a resident's guardian disagreeing about a community placement decision. Weaver Tr. 301:7-11, 402:17-402:24.

112. Ms. Weaver recalls only one individual on her caseload who was ever recommended for community placement. Weaver Tr. 401:22-402:10.

113. Sarah Murphy has worked at CHDC since 2001 and was a program coordinator for two and a half years. Murphy Tr. 434:9-19; *see* FOF ## 71-73 (responsibilities of CHDC program coordinators). Ms. Murphy cannot not identify any time in her two and a half years as a program coordinator in which an individual's treatment team concluded that an individual was appropriate for a more integrated setting without a guardian's support or agreement. Murphy Tr. 482:20-25.

114. Alan Fortney is the former President of the Conway Parent Association, the stepfather of a CHDC resident, and a frequent participant in his stepdaughter's annual IPP reviews. Fortney Tr. 1485:3-15, 1497:21-1498:5. He could not recall ever attending an annual review where the IDT disagreed about whether CHDC was the most integrated placement appropriate for his stepdaughter. Fortney Tr. 1494:7-23.

3) Local Providers of Community Services Are Currently Serving Individuals Who Need the Same Supports and Services as Residents of CHDC.

115. The testimony of local providers of community services that they can serve individuals with the same needs as those at CHDC further demonstrates that CHDC's assessments are not objective and reasonable. *See* FOF ## 116-140.

116. Four community service providers from throughout the State of Arkansas reviewed IPPs for 46 CHDC residents to determine whether they could provide services to CHDC residents in a more integrated setting. US Exs. 101-1, 102-1, 103-1, 105-1, 109-1, 111-1, 113-1, 114-1, 118-1, 126-1, 129-1, 131-1, 136-1, 137-1, 138-1, 139-1, 140-1, 143-1, 146-1, 148-1, 152-1, 156-1, 157-1, 163-1, 164-1, 165-1, 166-1, 167-1, 171-1, 172-1, 173-1, 175-1, 176-1, 177-1, 179-1, 180-1, 184-1, 185-1, 187-1, 192-1, 193-1, 196-1, 198-1, 199-1, 200-1 & 202-1 (redacted IPPs); *see* US Ex. 466 (Graca Decl. regarding redacted IPPs). These 46 IPPs represented a random selection of half the residents reviewed by community placement expert Richardson (21 residents), and half the residents reviewed by Defendants' consultant Kastner (25 residents). US Ex. 466 (Graca Decl. regarding redacted IPPs).

117. All four providers were confident that they could serve the vast majority of the 46 CHDC residents whose IPPs they reviewed. *See* FOF ## 119, 124, 134 & 140.

First Step

118. Provider Pamela Bland is the Executive Director of First Step, Inc., a provider of community services for approximately 1,600 people with developmental disabilities throughout Arkansas. Bland Tr. 860:10-862:1.

119. With the exception of approximately 5 individuals for whom she wanted more information, First Step could serve all of the individuals described in the 46 IPPs she reviewed in a more integrated setting than CHDC. Bland Tr. 896:21-897:17. Provider Bland reviewed the IPP of no individual at CHDC that she affirmatively could not serve in the community. Bland Tr. 896:21-897:17.

120. For example, First Step could serve KH in a more integrated setting. Bland Tr. 876:3-877:10; US Ex. 146-1 (Redacted IPP). KH is 30 years old and was admitted to CHDC in June

2001. US Ex. 146-1. His IPP lists the discharges services he needs as: "specialized nutritional services, habilitation services, psychological services, 24-hour care and supervision, physical and occupational therapy, nursing and medical interventions, dental, specialized recreational services." US Ex. 146-1 at 9. The CHDC team found that his guardians are "pleased" with his placement at CHDC and subsequently, teams made no alternative placement recommendations. US Ex. 146-1 at 3 & 9. Nevertheless, First Step can serve KH and currently serves similar individuals with similar needs and disabilities. Bland Tr. 876:3-877:21.

121. Similarly, First Step could serve MK. Bland Tr. 877:11-878:12; US Ex. 163-1 (Redacted IPP). He is 19 years old and was admitted to CHDC at the age of 16. US Ex. 163-1. He has cerebral palsy, seizure disorder, and hearing loss. Bland Tr. 877:11-878:12. MK's IDT identified some of his significant needs to be identifying coins, cooperating with brushing his teeth, and improving his behavior. US Ex. 163-1 at 18. His long range goals, as listed in his IPP, are to "independently participate in a group activity" by 2011, "obtain 3 daily living skills" to help him "function more independently in (his) home," and to "use the toilet independently." US Ex. 163-1 at 18.

122. MK's team concluded that CHDC is the least restrictive placement for him. US Ex. 163-1 at 16. The team found that MK's guardians are "pleased" with CHDC and that "the most appropriate transition plan for [MK] at this time would be for him . . . to continue to acquire the skills necessary to transition through the Team hierarchy at CHDC before he could successfully function in a community setting." US Ex. 163-1 at 16. However, community providers like First Step provide training in independent living skills. *See* FOF # 198. In addition, First Step "commonly" provides services in the community for individuals with the same discharge needs that are identified in MK's IPP. Bland Tr. 877:11-878:12; US Ex. 163-1 at 16 & 18.

ICM

123. Provider Cynthia Alberding is the Executive Director of Independent Case Management ("ICM"), a provider of community-based case management and direct services to over 450 people with intellectual and developmental disabilities, with approximately 240 receiving direct care services. Alberding Tr. 1327:23-1328:3, 1331:13-1332:12. ICM provides services throughout the state, including in rural areas. Alberding Tr. 1335:14-24.

124. ICM could serve the CHDC residents described in all 46 IPPs, if funding was not an issue. Alberding Tr. 1397:11-1398:1. Of the 46, ICM could clearly serve 35 of the individuals in a more integrated setting. Alberding Tr. 1355:2-22, 1379:13-20 (ICM could serve all 46 individuals but 11 individuals required more information about costs of care).

125. For the individuals for which provider Alberding needed more information, her concern was whether she could provide staffing for their behavior needs on the waiver cap of $391/day. Alberding Tr. 1355:23-1356:12. If waiver funding was not capped, she could provide community-based services to all 46 individuals. Alberding Tr. 1368:4-16.

126. In 2007, Arkansas's waiver expenditures per resident were $27,286. US Ex. 214 at 75. This is 33 percent less than the national average of $41,387. US Ex. 214 at 75. Arkansas's federal match for Medicaid costs is the second highest match rate in the nation – the federal government pays 73.37 percent of Arkansas's waiver expenditures. US Ex. 214 at 75, 77. ("As in all Medicaid programs, the federal government shares the costs of the ICF-MR and HCBS programs with the states as a function of the state per capita income relative to national per capita income").

127. Provider Alberding did not review any IPP for a resident who she thought definitely could not be served in the community. Alberding Tr. 1355:2-22.

128. Like First Step, ICM is also able to provide or secure each of the services that MK's CHDC team stated he must have before discharge is to occur. Alberding Tr. 1364:8-1366:23 ("Direct care supervision and assistance 24 hours, yes. Assistance for shopping, yes. Nutrition, yes. Transportation, yes. Emergency care, yes. Training/active treatment, yes. Special education, yes. Recreation and leisure services, yes. Behavioral intervention, yes. Psychiatric services, yes. Case management, yes. OT, PT, speech, yes.").

129. ICM is likewise able to serve JJ, who is 53 years old and was admitted to CHDC at the age of 11. Alberding Tr. 1372:16-1373:7; US Ex. 139-1 at 1 (Redacted IPP). JJ can "speak in short phrases or repeat most of what is said to him or from the TV." US Ex. 139-1 at 12. He can express preferences, keep time to music, and initiate interactions with other people. US Ex. 139-1 at 12-13. JJ's team identifies his long range goals as identifying items, completing hand usage activities, completing three daily living skills, and identifying work related objects. US Ex. 139-1 at 13.

130. JJ's CHDC team concluded that the institution is the least restrictive placement for him because JJ needs to "acquire the daily living (wipe traytop/identify body parts) and self-help skills (wipe mouth) necessary to function in a community setting." US Ex. 139-1 at 11. However, ICM can provide services to meet not only those daily skills-building needs, but also the additional discharge services listed as necessary in JJ's IPP. Alberding Tr. 1372:16-1373:23; *See* FOF ## 197 & 226 (ICM provides for daily living skills, behavioral needs and also additional discharge needs listed above).

131. ICM is also able to serve ER in a more integrated setting. Alberding Tr. 1374:3-1375:18; US Ex. 131-1 (Redacted IPP). ER is currently 46 years old and was admitted to CHDC when she was 9 years old. US Ex. 131-1. ER is ambulatory and likes to go outside. US Ex. 131-1 at

3. She can pour herself coffee, climb a fence, and use a treadmill. US Ex. 131-1 at 13. Her IDT identifies some of ER's significant needs as identifying quarters from a variety of coins, matching color cards, and improving her behavior. US Ex. 131-1 at 14. ER's team has identified her long range goals as doubling her work output and improving three self-help skills. US Ex. 131-1 at 14.

132. ER's team found that CHDC "remains the least restrictive setting" for her and that in order for her to transfer to a more independent setting, she "needs to enhance her self-help and daily living-skills and vocational skills." US Ex. 131-1 at 11. However, as already noted above, ICM provides training in daily living/independent living skills and, in addition, can provide for the discharge services listed as necessary in her IPP. Alberding Tr. 1374:3-1375:18; US Ex. 131-1 at 11-12; s*ee* FOF # 197.

Bost

133. Provider Jeff Lambert is the Assistant Executive Director of Bost, Inc., a provider of community services for approximately 700 people with developmental disabilities in northwest Arkansas. Lambert Tr. 1857:25-1858:12, 1859:16-23.

134. Of the 46 IPPs he reviewed, Bost could serve the individuals described in all of them if funding were not an issue. Lambert Tr. 1875:19-1878:1. Of the 46 individuals, Bost could serve 31 without any additional information. Lambert Tr. 1875:19-1878:1. For 9 with nursing care issues and 6 with behavioral health issues, provider Lambert wanted additional information to determine whether Bost could serve the individual under present waiver funding restrictions. Lambert Tr. 1875:19-1878:1.

135. For example, Bost could successfully serve RT, who is 68 years old and was admitted to CHDC in 1982. US Ex. 171-1 (Redacted IPP). RT "tends to entertain himself and enjoys

spending time on the lawn swing outside his residence or having a cup of coffee on the patio." US Ex. 171-1 at 3. He "gets along very well with other residents but sometimes appears tense or upset when other individuals become loud or disruptive in his residence." US Ex. 171-1 at 3. RT can communicate his wants and needs, get dressed with assistance, and toilet independently. US Ex. 171-1 at 11. His IPP list of significant needs includes "match coins by value," "select correct amount of simulated pills from a container," and "time to relax/rest." US Ex. 171-1 at 11-12.

136. CHDC's team concluded that CHDC "remains the least restrictive placement alternative" for him and that to be considered for alternate placement, RT "would need to perform his self-care tasks more independently and manage his Bipolar Disorder more independently." US Ex. 171-1 at 10. RT's IPP states that he would need the following services if discharged: "direct care/supervision (24 hour basis), immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; work/training sites, day programming; transportation, behavioral intervention and recreation/leisure services." US Ex. 171-1 at 10.

137. Bost can provide all of the services listed in RT's discharge/transition plan in a more integrated setting, including the self-care training and behavioral health services raised as a barrier by his team. Lambert Tr. 1878:2-1880:19, 1871:13-1874:16; US Ex. 171-1; *see* FOF # 227.

138. Bost has successfully provided community-based services to individuals discharged from CHDC including a medically fragile individual from the "Willow" residence at CHDC. Lambert Tr. 1864:11-1866:17, 1885:6-19.

Arkansas Support Network

139. Provider Keith Vire is Chief Executive Officer of Arkansas Support Network ("ASN"), a community-based services provider serving approximately 800 people with developmental disabilities, primarily in northwest Arkansas. Vire Tr. 1505:4-1508:5.

140. ASN could support and "support well" the individuals described in all 46 IPPs. Vire Tr. 1526:23-1527:22, 1540:24-1541:11; *see also* US Ex. 113-1; Vire Tr. 1528:6-1531:1 (ASN able to serve individuals with profound mental retardation); US Ex. 111-1; Vire Tr. 1531:2-18 (ASN successfully serves similar individuals with hearing impairments, chronic health problems, language delays, aggression and self-injurious behavior); US Ex. 143-1; Vire Tr. 1533:14-1536:14 (ASN can serve individual with behavioral issues who needs learn personal care skills); US Ex. 202-1; Vire Tr. 1537:24-1540:23 (ASN can serve individuals who have lived at CHDC for a long time).

141. ASN is able to serve individuals with diagnoses of "profound mental retardation." Vire Tr. 1528:6-1531:1; US Ex. 113-1 (Redacted IPP). This includes individuals like BM, who is 20 years old and was admitted to CHDC at the age of 7. US Ex. 113-1 at 1. BM prefers one-to-one attention from family, friends, and staff. US Ex. 113-1 at 3. His team concluded that CHDC "remains the least restrictive alternative" for him. US Ex. 113-1 at 10. However, ASN could serve BM in a more integrated setting. Vire Tr. 1526:23-1527:1, 1528:8-14 ("this is a person who could really thrive in a community setting").

142. ASN successfully serves individuals, similar to BB, who have hearing impairments, chronic health problems, language delays, aggression, and self-injurious behavior. Vire Tr. 1531:2-18; US Ex. 111-1 (Redacted IPP). BB is 18 years old and was admitted to CHDC at the age of 13. US Ex. 111-1 at 1. He has many independent and daily living skills including the

ability to dress/undress himself, feed himself, and take out the trash. US Ex. 111-1 at 3. He can identify coins, brush his teeth, and "operate a coke machine." US Ex. 111-1 at 17. During home visits, BB visits with family, watches TV, plays with toys, and goes shopping. US Ex. 111-1 at 3. His treatment team identified his significant needs as stacking paper, pouring medicine from a bottle into a cup, and opening a Band-Aid package. US Ex. 111-1 at 17.

143. The CHDC team concluded that institutionalization "remains the least restrictive alternative" for BB because he needs to "continue to learn skills in personal hygiene, prevocational skills, money management, and self-administration of medication to assist in preparing him with the tools necessary to move up the Team hierarchy and to eventually successfully function in the community." US Ex. 111-1 at 15. However, ASN can serve BB and individuals who have disabilities similar to BB in a more integrated setting. Vire Tr. 1531:2-18, 1521:8-1522:1 (Acquisition of self-care skills and independent living skills is not a barrier to transition to participation in ASN's community service programs); US Ex. 111-1; *see* FOF ## 197-198.

144. ASN can serve JW, who is 22 years old and was admitted to CHDC in October 2006. Vire Tr. 1533:14-1536:14; US Ex. 143-1 at 1 (Redacted IPP). His IPP states that he is "totally dependent" on others to provide care for him. US Ex. 143-1 at 3. His IPP also finds that in order for JW to be successful in the community, he would need an "attendant for personal care, grooming, hygiene; specialized nutritional/dietary services; transportation services; communication facilitator; specialized medical services including OT and PT; work skills training and supervision; and recreational services." US Ex. 143-1 at 12. Even though his team concluded that CHDC remains the least restrictive alternative for him, US Ex. 143-1 at 12, ASN currently serves individuals who, like JW, have behavioral issues and need to learn personal care

skills. Vire Tr.1533:14-1536:14; *see* FOF ## 198 & 228 (ASN serves individuals with developmental disabilities who have extremely challenging behaviors and mental health issues).

145. ASN can also serve individuals like WC, who have lived at CHDC for a long time. Vire Tr. 1537:24-1540:23; US Ex. 202-1. WC is 50 years old and was admitted to CHDC when he was 14. US Ex. 202-1 (Redacted IPP). He can eat with utensils, dress/undress himself, make his bed, fold laundry, buckle his own seatbelt, clean small appliances, and use a staple puller. US Ex. 202-1 at 11-12. WC's team identified his significant needs as "clean oven with less prompts," arrive on time for work, and improve tooth brushing. US Ex. 202-1 at 12. His IPP identifies his discharge service as "direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; communication facilitator; day programming; work sites/situations, transportation and recreation/leisure services." US Ex. 202-1 at 10.

146. WC's team concluded that CHDC "remains the least restrictive alternative" for him and that to be considered for alternate placement, WC "would need to have his behaviors of aggression under better control, expand his work skills, and perform self-care/daily living skills more independently." US Ex. 202-1 at 10. However, as noted above, ASN provides training for those individuals who need more personal care skills and services for those with behavioral issues. Vire Tr. 1533:14-1536:14; *see* FOF ## 198 & 228. In addition, ASN has successfully served individuals who have lived in institutions for long periods of time. Vire Tr. 1538:5-1539:2.

147. Although funding might be an issue for some medically fragile individuals, ASN could serve all 46 individuals represented in the redacted IPPs if there was no cap on waiver services. Vire Tr. 1561:22-1562:8.

4) CHDC Staff Conceded That Many Individuals at CHDC Can Be Served in More Integrated Settings.

148. CHDC staff admitted that some residents who are not currently recommended for a more integrated setting could nevertheless have their needs met in the community. *See* FOF ## 149-157.

149. For example, in a discussion of CHDC resident LW, CHDC program coordinator Sarah Murphy acknowledged that community providers could provide the "consistency and structure" identified as a key reason that CHDC is an appropriate placement for him. Murphy Tr. 475:19-476:10; US Ex. 153. Nevertheless, his interdisciplinary team concluded that CHDC is the least restrictive environment for him. US Ex. 153 at 18.

150. In a discussion of CHDC resident NP, CHDC program coordinator Donna Clendenin testified to her belief that the services necessary to meet NP's needs are available in the community. Clendenin Tr. 1590:12-1594:4. Nevertheless, his interdisciplinary team identified CHDC as the least restrictive setting for him. Clendenin Tr. 1590:12-23; US Ex. 166 at 10.

151. Similarly, during a discussion of CHDC resident DB, Ms. Clendenin testified to her belief that the services necessary to meet his needs are available in the community. Clendenin Tr. 1609:20-1611:24; US Ex. 122. His interdisciplinary team identified CHDC as the least restrictive setting for him. US Ex. 122 at 12.

152. Likewise, during a discussion of CHDC resident JB, Ms. Clendenin testified to her belief that the services JB needs are available in a more integrated setting. Clendenin Tr. 1628:19-1629:10; US Ex. 142.

153. Several CHDC staff admitted that community services providers can provide the training identified in CHDC residents' IPPs as a prerequisite for consideration for community placement.

For example, Ms. Rebecca Brewer, a CHDC team leader, testified that many of the skills taught to residents at CHDC, such as "hygiene, self-care skills, baking," are taught by providers in more integrated settings. R. Brewer Tr. 6753:3-12.

154. CHDC program coordinator Sarah Murphy testified that CHDC residents should not be barred from placement in a more integrated setting because they need to acquire self-care skills and greater independence. Murphy Tr. 477:22-478:6.

155. In his own community practice, CHDC's chief psychologist sees residents with the same types of medical and other issues related to their developmental disabilities that he sees in CHDC residents, and those individuals in the community are being adequately served in the community. Reddig Tr. 2020:15-24.

156. Similarly, CHDC psychological examiner, Anita Cooper, testified that many of the behavioral services provided at Conway, such as interviewing staff to assess residents or training staff on strategies on managing behaviors, can "probably" be provided in the community as well. Cooper Tr. 2421:4-8, 2454:6-2455:12.

157. The speech-language services offered at CHDC can be provided in a community setting. Johnson Tr. 5399:17-5401:3.

5) CHDC Treatment Teams Lack Sufficient Information or Knowledge Necessary To Make Objective, Reasonable Assessments Regarding the Most Integrated Setting Appropriate for Individuals at CHDC.

158. The CHDC staff who participate in the interdisciplinary teams, including the annual review meetings, and make decisions regarding the most integrated setting appropriate for CHDC residents, must have an accurate understanding of what services are available in the community and what the benefits are of living in an more integrated setting. Richardson Tr.

607:21-608:8, 611:25-613:3, 616:17-617:13, 628:22-630:5 (CHDC needs a "real education effort to help people understand how important community services are and to get to know them, to get to know them well.").

159. Treating professionals at CHDC, however, do not have sufficient knowledge and training regarding community integration and community options to provide objective, reasonable assessments to individuals and their guardians. Richardson Tr. 611:10-24, 615:7-10. As a result, CHDC residents and guardians do not receive sufficient information from CHDC about the supports and services available, and the possibilities and benefits of a more integrated setting. Richardson Tr. 616:17-618:6; US Ex. 264; *see* FOF ## 299-317.

160. Angela Green, the CHDC director of social services and staff person most knowledgeable about community placement, is not familiar with all of the services available in the community, for example, what daily living skills are necessary or what behavioral skills are required. A. Green Tr. 826:11-828:25.

161. Ms. Green was not even aware of the existence of a DDS waiver guide until April 2010, when a community service provider gave her a copy. A. Green Tr. 6797:17-25 ("Pathfinder had copies of this [the ACS waiver guide]."). At her deposition Ms. Green was unable to identify any benefits of living in settings more integrated than CHDC, other than being able to choose where one lives. A. Green Tr. 829:8-830:9. Only in response to defense counsel's obviously leading questions was Ms. Green able to identify any other benefits of living in more integrated settings. A. Green Tr. 848:23-849:13.

162. The social service workers that Ms. Green supervises receive little to no formal training regarding more integrated placements available in Arkansas. A. Green Tr. 820:25-821:22, 825:7-14 (testifying that in nine years, DDS has done three trainings for program specialists

/social workers at CHDC). Nor do they receive any formal training on the ADA. A. Green Tr. 824:11-20. Nevertheless, they are "responsible for providing information to residents and guardians for residents on their caseload about community placement options." A. Green Tr. 819:23-820:10. They are also responsible for helping residents and guardians locate an appropriate placement when requested. A. Green Tr. 819:23-820:10.

163. CHDC Superintendent Price is not familiar with what services are offered outside of CHDC by Arkansas's community providers. Price Tr. 1710:8-21. Superintendent Price does not know what types of behavioral services are available in the community. Price Tr. 1711:14-17.

164. Superintendent Price does not know what services, if any, CHDC provides that cannot be obtained through a community program. Price. Tr. 1715:10-1716:4 ("I'm not sure. I don't know. It gets back to I'm not quite sure what all those community providers, what type of services that they offer in their individual programs, so I would have a tough time answering that one . . . . I'm just not sure what a lot of the programs have to offer as far as those services. Many of the programs we've heard here today are basically – are nonresidential programs, so I'm really not sure what type of those services that they offer. I'm really not.").

165. Similarly, CHDC team leaders have little understanding of what supports and services are currently available in community programs. Richardson Tr. 615:15-616:3; *see* FOF # 67 (responsibilities of CHDC team leaders). For example, one team leader informed Ms. Richardson that she had not investigated community placements, had not read about them, and did not know much about them. Richardson Tr. 615:15-23. Another team leader said that he knew community placement was an option, but that CHDC was the best so it was not necessary to spend time on the issue. Richardson Tr. 615:25-616:3.

166. The trial testimony of CHDC team leaders underscores their lack of knowledge and training about community placement options. For example, Rebecca Brewer testified that she hasn't visited a community placement in "over ten years," R. Brewer Tr. 1478:16-20, and does not "have a sense of the specific services that are offered in the community." R. Brewer Tr. 1478: 16-25; *see* FOF ## 67 & 69 (Team leader Rebecca Brewer is the current team leader of the HTT, the team from which the majority of CHDC residents transition to more integrated settings).

167. In fact, Ms. Brewer admitted that she does not believe that placements in the community provide the same quality of services that are available at CHDC. R. Brewer Tr. 1479:1-4.

168. When asked how many residents from one CHDC team, HTT, had been identified as appropriate for a more integrated setting and are currently waiting for placement, Ms. Brewer estimated that "close to ten" HTT residents were currently on the waiting list for community placement. R. Brewer Tr. 1479:5-15. In fact, CHDC identified only four residents in the entire facility as appropriate for a more integrated setting. A. Green Tr. 836:16-837:9; US Ex. 284-1.

169. Team leader of CHDC team SLT, Doug Hart oversees the care of 105 residents and supervises 165 staff members. Hart Tr. 1926:14-21. Mr. Hart has never visited a community placement in Arkansas or any other state. Hart Tr. 1927:23-1928:2. Mr. Hart does not have any "sense what services are available in the community," or what the significant barriers to transitioning to a more integrated setting are for the residents on his team. Hart Tr. 1928:3-5, 1928:11-16. He has not received any training on community integration or community placement since working at CHDC and, prior to having his deposition taken by the United States in April 2010, was not familiar with the term "Olmstead Plan." Hart. Tr. 1928:17-1929:12.

170. Likewise, Larry Brewer supervises approximately 180 staff and 66 residents as the IAT team leader. L. Brewer Tr. 1460:10-18; 1462:3-5. As team leader, he is also supposed to provide clinical supervision to the program coordinators. L. Brewer Tr. 1463:4-7; US Ex. 279; R. Brewer Tr. 1474:24-1475:1; Hart Tr. 1927:2-4. Mr. Brewer erroneously believes that there are not more integrated settings than CHDC in Arkansas that could serve a school-aged individual who has "self-help skill needs [and] aggression." L. Brewer Tr. 1467:2-6; *see* FOF ## 197, 198 & 225-228 (Community providers can serve children who have aggressive behaviors and/or need self-help skills.).

171. For more than two years, Judy Weaver served as a CHDC program coordinator without any knowledge about what services existed in the community. Weaver Tr. 403:16-404:11; *see* FOF ## 71-73 (responsibilities of a program coordinator).

172. Program coordinator Judy Weaver has not visited a community provider, received training on the ADA, or received training on the Supreme Court's decision in *Olmstead v. L.C.* Weaver Tr. 406:5-406:25.

173. CHDC program coordinator Sarah Murphy believes CHDC is an "integrated setting." Murphy Tr. 504:2-6.

174. Ms. Murphy's knowledge of what services are available in the community is limited to her personal internet research, what CHDC social workers have told her, and informal conversations with community providers. Murphy Tr. 505:11-506:4.

175. Program coordinator Murphy has not visited community providers in her role at CHDC. Murphy Tr. 4944:8-20 ("I can't think of any I've been to.").

176. Ms. Murphy was the program coordinator for CHDC resident TC, but did not know whether all of the services TC needed could be provided in the community. Murphy Tr. 473:22-475:18; US Exs. 191 & 191-2.

177. CHDC's training curriculum discusses community integration policy but contains no substantive training about community placement, community services, or the Arkansas ACS waiver program. Richardson Tr. 611:10-24. For example, the CHDC new employee certification, US Ex. 226, does not include any documents with information about community services and how they relate to CHDC nor any discussion of the relationship between community services and residents' opportunities to live and experience a more integrated setting. Richardson Tr. 611:25-612:21.

178. Similarly, the CHDC annual retraining outline, US Ex. 227, contains no information indicating that transition to more integrated settings is part of the training. Richardson Tr. 613:4-16; US Ex. 227.

179. One CHDC PowerPoint training contains a few slides touching on least restrictive environments, waiver, and deinstitutionalization. Richardson Tr. 613:20-614:9; US Ex. 228. This is the only substantive information regarding community integration for CHDC employees. Richardson Tr. 614:2-9; US Ex. 228.

180. Arkansas community providers, such as Pathfinders, Easter Seals, and United Cerebral Palsy, are not invited to provide regular training at CHDC regarding their services, nor does CHDC communicate with many community providers about their services. Richardson Tr. 590:23-591:15, 614:23-615:6; Bland Tr. 866:2-867:12; Alberding Tr. 1338:17-20; Lambert Tr. 1866:18-1869:16; Vire Tr. 1523:10-19.

181. CHDC teams demonstrated their lack of sufficient training at annual review meetings, by failing to substantively discuss community placement. Richardson Tr. 616:12-617:21; *see* Richardson Tr. 549:11-550:4.

182. Psychology staff receive little or no training on how to assess residents for community placement or how to implement federal statutes requiring treatment in the most integrated or least restrictive setting. Cooper Tr. 2453:20-2454:5.

6) Individual Program Plans Demonstrate CHDC's Failure To Conduct Objective, Reasonable Assessments of Whether Individuals are Appropriate for a More Integrated Setting.

183. CHDC Individual Program Plans reflect CHDC's failure to provide objective, reasonable assessments. They are generic, repetitive, and identify non-existent barriers to placement in a more integrated setting. *See* FOF ## 79, 80 & 82 (Requirements for CHDC program plans).

184. Thus, of the 40 IPPs that community placement expert Richardson reviewed, she found that the vast majority did not reflect an adequate assessment of whether the individuals described could be served in a more integrated setting, as required by the ADA and CHDC's own policies. Richardson Tr. 552:22-553:1 ("What I was saying is these people need to be looked at more carefully and a more thorough transition plan needs to be designed so that it can be very clear what the benefits might be and what kind of services would need to be explored in order to make an appropriate community placement for these people."), 553:11-25, 557:24-558:6.

185. Based on her examination of 40 IPPs, Ms. Richardson concluded that most of the individuals at CHDC did not receive a reasonable assessment and needed a more careful and individualized evaluation to determine how they could benefit from a more integrated placement and what specific services would be necessary. Richardson Tr. 550:5-552:5, 553:18-554:2.

186. The absence of reasonable assessments at CHDC prevents further development of community services. Richardson Tr. 618:7-23. Without detailed information about CHDC residents who could live in a more integrated setting, including accurate information about what services they would need, providers of community-based services cannot develop or increase the availability of those services so as to create further opportunities for CHDC residents. Richardson Tr. 618:7-23.

187. Individual program plans demonstrate CHDC's failure to provide objective, reasonable assessments and reflect CHDC staff's lack of knowledge and training regarding community integration. Richardson Tr. 611:2-6.

188. CHDC individual program plans are generic and repeatedly identify the same illegitimate barriers to transition to a more integrated setting, such as the need to acquire daily living skills or rectify behavioral issues. Richardson Tr. 529:2-9, 610:27-611:9. Furthermore, CHDC IPPs fail to describe the specific services that are necessary for a resident to successfully transition out of CHDC. Richardson Tr. 529:2-9, 551:21-552:5.

i. CHDC Teams Use the Acquisition of Skills as an Inappropriate Barrier to Placement in a More Integrated Setting.

189. In 11 of the 40 IPPs that community placement expert Richardson reviewed, the IDT required the acquisition of skills of some sort before the individual could be placed in a more integrated setting, or included language regarding needing more independence or self-help skills in order to secure community placement. Richardson Tr. 560:24-561:12, 579:21-580:17. These IPPs require that individual residents "earn" their way into a community placement or learn social skills or basic self-care skills in order to qualify for more integrated setting. Richardson Tr. 529:23-530:8, 551:12-20.

190. LR is 57 years old and was admitted to CHDC on January 19, 2000. US Ex. 149 at 1. His IPP states that in order to move to a less restrictive environment he "would need to acquire more independent self-care skills and be able to follow daily activities with less assistance." US Ex. 149 at 11.

191. KF is 19 years old and was admitted to CHDC on December 11, 2006. US Ex. 148. Her IPP states that the acquisition of independent living skills is a requirement before discharge is appropriate. US Ex. 148 at 13 ("For discharge to be appropriate, [KF] will need to be more independent in following a daily routine (for basic self-care and daily living)."); Richardson Tr. 559:23-561:5.

192. WF is 70 years old and was admitted to CHDC on April 22, 1975. US Ex. 199 at 1. As in KF's IPP, the transition/discharge plan in WF's IPP notes that in order to be considered for community placement WF must "improve self-care and communications skills, and expand work skills." US Ex. 199 at 11.

193. JN is 40 years old and was admitted to CHDC on March 7, 1978. US Ex. 134 at 1. As with KF and WF, the transition/discharge plan in JN's IPP states that he "would need to be more independent in self-care and have his aggression under control" to be considered for community placement. Richardson Tr. 585:12-586:1; US Ex. 134 at 12.

194. Many other CHDC IPPs contain boilerplate, inappropriate skill acquisition requirements as part of the discharge/transition plan. US Exs. 105 at 9 (IPP for AN), 112 at 14 (IPP for BR), 115 at 14 (IPP for CL), 121 at 12 (IPP for CA), 122 at 12 (IPP for DB), 124 at 11 (IPP for DG), 126 at 11 (IPP for DN), 127 at 10 (IPP for ET), 132 at 15 (IPP for HB), 135 at 11 (IPP for JR), 138 at 14 (IPP for JM), 142 at 12 (IPP for JB), 145 at 13 (IPP for KH), 160 at 14-15 (IPP for ME), 161 at 15 (IPP for MF), 162 at 13 (IPP for MD), 167 at 10-11 (IPP for OM), 176 at 20 (IPP

for RK), 179 at 10 (IPP for RD), 181-2 at 12 (IPP for RC), 194 at 17 (IPP for TH), 206 at 15 (IPP for ZS), 561-21 at 12 (IPP for SA), 562-3 at 11(IPP for MB), 563-34 at 11-12 (IPP for GB) & 566-18 at 15 (IPP for DB); *see also* US Exs. 103-1 at 16, 109-1 at 17, 111-1 at 15, 114-1 at 10, 131-1 at 11, 136-1 at 14, 139-1 at 11, 140-1 at 9, 152-1 at 9-10, 156-1 at 12-13, 163-1 at 16, 165-1 at 12, 171-1 at 10, 172-1 at 14, 175-1 at 10, 180-1 at 13, 185-1 at 11, 187-1 at 11, 196-1 at 12 & 198-1 at 11 (redacted IPPs).

195. The acquisition of daily living skills, as used by CHDC IDTs, is not a legitimate reason for precluding individuals from a setting more integrated than CHDC. Richardson Tr. 561:13-25. Such conditional statements inappropriately place the burden on the individual to earn placement outside of CHDC. Richardson Tr. 562:1-6. It is, in addition, an outdated concept in the field of developmental disabilities, and as such, the acquisition of such skills is not a necessary ingredient for moving into a more integrated setting. Richardson Tr. 578:25-579:15, 580:3-17.

196. Community providers can and do train individuals with intellectual and developmental disabilities in basic self-care and social skills so that qualifying for placement by learning or acquiring those skills is not necessary. Richardson Tr. 561:18-25 ("Community providers teach those skills, so you really don't have to have them to go into a community setting."), 529:23-530:8.

197. Providers of community-based services for individuals with developmental disabilities, such as Independent Living Services, Inc., Easter Seals, Pathfinders, Inc., and United Cerebral Palsy, are able to provide or secure the independent living skills training and daily living services that are identified in CHDC IPPs. Richardson Tr. 591:16-25, 592:11-593:16 (provided services

include nursing care, direct supervision/24-hour care, adaptive equipment, occupational therapy and physical therapy).

198. In addition, all of the local community providers that testified at trial stated that their organization provides training in these areas, including independent self-care skills and daily living skills. Bland Tr. 892:4-895:5, 896:12-20, 900:17-21; Alberding Tr. 1347:22-1351:12; Lambert Tr. 1871:13-1874:16; Vire Tr. 1512:19-1516:22, 1521:8-1522:1 (testifying that acquisition of self-care skills and independent living skills is not a barrier to transition to a more integrated setting whether that setting is supported with community services provided by ASN or any other program in the state).

199. It is quite possible that some individuals with developmental disabilities may never gain some basic daily living skills, yet they can effectively be served in a more integrated setting. Richardson Tr. 605:11-15, 561:18-25, 529:25.

200. For example, many CHDC IPPs include the need for institutionalized residents to learn how to brush their teeth even though few residents can brush their teeth to the satisfaction of the institution. Richardson Tr. 605:11-18.

201. Ms. Richardson testified that she does not know of any states where children are institutionalized because they cannot brush their teeth, comb their hair, or count money. Richardson Tr. 610:16-19.

202. Nevertheless, CHDC requires that such skills be acquired before some individuals will be considered for a more integrated setting. Richardson Tr. 610:20-611:1. The use of such barriers reflects that the teams at CHDC do not understand what community providers can do in terms of teaching residents about skill development. Richardson Tr. 611:2-6. Such requirements also indicate that such plans are incomplete. Richardson Tr. 611:7-9.

203. IPPs as recent as June 2010 contained long-range goals to improve an individual's skills in order to function better at CHDC. Murphy Tr. 4952:16-4953:17; US Ex. 134-2 at 15 (IPP for JN) ("By 2011, I will have self-help, daily living skills, and communication to function more independently in my present residence.").

ii. CHDC Teams Use the Transition of Residents Through the CHDC Team Hierarchy as an Inappropriate Barrier to Placement in a More Integrated Setting.

204. Many CHDC IPPs state that individual residents must progress through CHDC's five-team structure in order to be placed in a more integrated setting. Richardson Tr. 578:7-21; *see* US FOF # 66 (CHDC team structure). The concept of requiring progress through an institution's team structure is outdated, unnecessary, and inappropriate. Richardson Tr. 578:7-579:12. Recommendations regarding placement in more integrated settings should be designed to fit the needs of individuals and not depend on whether individuals have earned a more integrated placement. Richardson Tr. 579:12-14.

205. CHDC staff state that this concept is no longer implemented. Richardson Tr. 578:7-21. Nevertheless, many IPPs contain language demonstrating that CHDC still uses the concept of an individual transitioning through the teams in order to be considered for or placed in a more integrated setting. Richardson Tr. 578:25-579:5; *see* US FOF ## 197, 198, 225-228 (Arkansas community-based service providers serve individuals who need skills training and have behavioral health issues).

206. For example, RN is 52 years old and was admitted to CHDC on February 8, 2000. US Ex. 176. RN's IPP contains the following language under the heading "placement issues": "The most appropriate transition plan for [RN] at this time would be for him to acquire the skills

necessary to transition through the Team hierarchy at CHDC before he could successfully function in a community setting." US Ex. 176 at 20.

207. Likewise, RC is 30 years old and was admitted to CHDC on October 26, 2000. Richardson Tr. 577:1-4; US Ex. 173. Her IDT concluded that in order for her to successfully function in a community setting, she must acquire the independent and communication skills necessary to "transition through the Team hierarchy at CHDC." Richardson Tr. 578:2-6; US Ex. 173 at 10.

208. JM is 23 years old and was admitted to CHDC on April 16, 2004. US Ex. 138. His IPP states, "[t]he Team agreed the most appropriate transition plan for [JM] is for him to move to a higher functioning Team and continue to gain the skills (independence in personal care, daily living, vocational skills, and improved behavior) needed in order to move up the Team hierarchy prior to successfully functioning in the community." US Ex. 138 at 14.

209. ZS is 12 years old and was admitted to CHDC on August 7, 2007 – for what was supposed to be a temporary placement until waiver services could be set up for him. US Exs. 206, AG-1; A. Green Tr. 6802:21-25. Yet his IPP also concludes that "the most appropriate transition plan for [ZS] at this time would be for him to acquire the skills necessary to transition through the Team hierarchy at CHDC before he could successfully function in a community setting." US Ex. 206 at 15.

210. AN's plan includes the following language: "The optimal transition plan for [AN] is to continue training in personal hygiene/grooming skills and training to foster independence with the desired outcome of transition through the team hierarchy at the Center and eventual community placement." US Ex. 105 at 9.

211. HB is 14 years old and was admitted to CHDC on March 8, 2005. US Ex. 132. His IPP states that "the team agreed the most appropriate transition plan for [HB] is continue to learn skills in personal hygiene, money management, daily living, and behavior improvement prior to moving up the Team hierarchy and successfully functioning in the community. US Ex. 132 at 15.

212. ME is 48 years old and was admitted to CHDC on June 6, 1968. US Ex. 160. His IPP states that "the Team agreed the most appropriate transition plan for [ME] is that he continue to learn skills in personal hygiene, daily living, prevocational tasks, and that he improve his behavior. The above areas are possible barriers to him transitioning up through the Team hierarchy prior to successfully functioning in the community." US Ex. 160 at 15.

213. CA is 18 years old and was admitted to CHDC on September 21, 2006. US Ex. 121. His IPP states that "to transition to a less restrictive setting, [CA] needs to acquire the skills (vocational, daily living) to move through the Team hierarchy at CHDC." US Ex. 121 at 12.

214. MF is 24 years old and was admitted to CHDC on January 16, 2008. US Ex. 161. His IPP states, "the most appropriate transition plan for [MF] at this time would be for him to acquire the skills necessary to transition through the Team hierarchy at CHDC before he could successfully function in a community setting." US Ex. 161 at 15; *see also* US Exs. 109-1 at 17, 111-1 at 15, 163-1 at 16, 196-1 at 12 (Redacted IPPs with similar or identical "transition through the team hierarchy" language).

iii. CHDC Teams Use Behavioral Improvements as an Inappropriate Barrier to Placement in a More Integrated Setting.

215. Similarly, CHDC interdisciplinary teams inappropriately raise behavioral health issues or the necessity of improving behavior as a barrier to potential placement in a more integrated setting. Richardson Tr. 551:12-20.

216. With the right supports, individuals with behavioral health issues can succeed in a setting more integrated than CHDC. Richardson Tr. 560:15-23, 603:1-8. In fact, changing an individual resident's environment by reducing distractions and increasing personal attention can potentially improve an individual's behavior. Richardson Tr. 603:1-8; *see* US FOF # 36 (Expert Matson testified that children in institutions learn maladaptive behaviors from one another).

217. CHDC's own Strategic Plan supports this conclusion by calling for a reduction in the number of individuals at CHDC in order to increase personal space. Richardson Tr. 603:9-13; US Ex. 235.

218. CHDC Superintendent Calvin Price testified that for some individuals, less personal space can exacerbate violent and other maladaptive behaviors. Price Tr. 1682:6-15.

219. The IPP for DG is an example of how CHDC uses behavioral improvement as a barrier to community placement. DG's IDT concludes that one of the things she has to do in order to be considered for a less restrictive setting is learn to handle frustrating situations better and, specifically, without destroying clothing. Richardson Tr. 601:24-602:4; US Ex. 124 at 11. DG's IPP notes that she has some behavior issues, including the fact that she tears clothing and tries to flush it down the toilet. Richardson Tr. 602:7-9; US Ex. 124:4. Expert Richardson testified that her behaviors are a response to frustration and that this frustration may be reduced in a less crowded environment. Richardson Tr. 602:16-22. A change in an individual's environment,

reduction in distraction, and an increase in personal attention can increase an individual's ability to handle such behaviors. Richardson Tr. 602:16-22.

220. Likewise, the IPP for JR notes that in order to be considered for a less restrictive environment, he needs to follow his routine without continued staff direction and learn to express his anxiety and frustration without aggression. US Ex. 135 at 11. JR's IPP notes that his behaviors included destruction of property and crying – actions attributed to attempts to get attention. US Ex. at 11; Richardson Tr. 604:13-18. JR does not have significant behavioral issues when he visits his parents at their home, during off-campus outings, or in the recreation room. Richardson Tr. 604:19-22, 743:24-744:3; U.S. Ex. 135 at 3, 8, and 9 (JR also works at a restaurant off-campus.). If JR were to be placed in a more home-like environment and felt comfortable, those behaviors may decrease. Richardson Tr. 604:24-605:3.

221. JB is 17 years old and was admitted to CHDC on March 18, 2009. US Ex. 142 His IPP states that "to be considered for alternate placement [JB] would need to be able to perform self-care needs without constant monitoring; express his frustration/agitation in acceptable social mannerisms, and show more awareness and concern for his personal safety." *Id.* at 12.

222. The IPP for JN is an example of how CHDC uses behavioral improvement as a barrier to community placement. The IPP notes that he needs to have his aggression under control to be considered for community placement. US Ex. 134 at 12; Richardson Tr. 585:19-586:1.

223. Many CHDC IPPs contain the same or similar requirements regarding improvement in behavior as part of the discharge/transition plan. Richardson Tr. 551:12-20; US Exs. 115 at 14 (IPP for CL), 122 at 12 (IPP for DB), 132 at 15 (IPP for HB), 134 at 12 (IPP for JN), 138 at 14 (IPP for JM), 145 at 13 (IPP for KH), 148 at 13 (IPP for KF), 160 at 15 (IPP for ME), 191-2 at 18 (IPP for TC), 562-3 at 11 (IPP for MB), 563-34 at 12 (IPP for GB), 132 at 15 (IPP for HB),

561-21 at 12 (IPP for SA), 566-21 at 15 (IPP for DB), 579-15 at 12 (IPP for CW); *see also* 103-1 at 16, 165-1 at 12, 172-1 at 14, 180-1 at 13, 185-1 at 11 (redacted IPPs).

224. Nevertheless, every Arkansas community provider who testified at trial stated that their organizations serve individuals with behavioral issues in settings that are more integrated than CHDC. US FOF ## 225-228.

225. Community services provider First Step can serve children and adults with developmental disabilities who have behavioral issues, including individuals who express agitation in socially unacceptable ways, have explosive behaviors, need 24-hour direct-care, are unconcerned for their personal safety, and/or who have co-occurring mental health needs. Bland Tr. 892:4-895:5, 900:17-21, 896:12-20, 925:19-926:5.

226. Community services provider ICM provides behavioral services and serves individuals with developmental disabilities who need 24-hour direct care, cannot express agitation in a socially acceptable manner, have explosive behaviors and/or aggression, and do not appear to have concern for their personal safety. Alberding Tr. 1347:22-1351:12, 1351:13-1352:5.

227. Community service provider Bost, Inc., serves "numerous individuals that have severe, severe behaviors." Lambert Tr. 1909:8-20. Bost provides services for individuals with developmental disabilities who have serious mental health issues, explosive behaviors, aggression, are not good at following directions, and have significant behavioral needs. Lambert Tr. 1871:13-1874:16. Bost has never refused to serve anyone due to the seriousness of their behavioral needs. Lambert Tr. 1909:8-20.

228. Community service provider Arkansas Support Network serves individuals with developmental disabilities who have extremely challenging behaviors and mental health issues including children with serious behavioral needs. Vire Tr. 1511:8-1512:8,1512:19-1515:18.

iv. CHDC Teams Use Residents' Medical Needs As an Inappropriate Barrier to Placement in a More Integrated Setting.

229. Similarly, CHDC interdisciplinary teams inappropriately raise residents' medical needs/physical health issues as barriers to potential placement in a more integrated setting. Richardson Tr. 601:2-8. Individuals with developmental disabilities and significant health needs can live in the community with appropriate supports. Richardson Tr. 574:22-25.

230. In her 40 years of work with individuals with developmental disabilities, community placement expert Richardson has met many individuals with developmental disabilities, like those CHDC residents described below, who have significant medical needs but live in more integrated community settings. Richardson Tr. 574:22-25, 575:1-3, 601:2-5; US FOF ## 235-238.

231. For example, TR's IPP describes him as having significant medical issues, which include cerebral palsy with spastic quadriplegia and some associated issues regarding his skin and ability to swallow. Richardson Tr. 600:20-601:1; US Ex. 193. Individuals with developmental disabilities like TR can live in the community with appropriate services. Richardson Tr. 601:2-5.

232. Expert Richardson reached this same conclusion regarding SH, though he has significant health needs as well. Richardson Tr. 574:11-20; US Ex. 186 (SH is non-ambulatory and has low verbal skills.).

233. Likewise, SA has significant health needs including the fact that she is nonverbal, walks with assistance, and may need tube feeding. US Ex. 184 at 12. Her discharge/transition plan does not contain any information as to why CHDC is the least restrictive environment appropriate for her needs. US Ex. 184 at 3. SA's transition/discharge plan is generic and not individualized to her needs, as demonstrated by the following list of services and supports: "24-

hour direct care supervision and assistance; specialized medical/dental services; specialized nutritional services, eating equipment and G-tube feeding equipment; Habilitation training; psychiatric services and behavioral intervention; therapies (PT); recreation and leisure services; specialized transportation and accessibility." Richardson Tr. 581: 20-22; US Ex. 184 at 12; *see also* US Exs. 101-1 at 15, 102-1 at 15, 152-1 at 9-10, 157-1 at 3, 177-1 at 14-15 (Redacted IPPs).

234. Expert Richardson had the opportunity during her tour of more integrated settings outside CHDC to meet a woman with developmental disabilities who had considerable physical limitations and needed help with all aspects of her daily living, but was living in an apartment/group home as part of the ACS waiver program. Richardson Tr. 575:4-14, 575:22-23. This individual's limitations included the need for a special lift to transfer her from a bed to a chair, a special arrangement for bathing and assistance from other individuals for eating and dressing. Richardson Tr. 575:15-21.

235. Providers of community services for individuals with developmental disabilities in Arkansas provide services for individuals with significant medical issues. US FOF ## 236-238. First Step provides services for both children and adults with serious medical issues, Bland Tr. 892:4-895:5; 896:12-20, 900:17-21, and serves such individuals in non-dormitory settings that also include non-medically fragile individuals. Bland Tr. 883:18-884:4. First Step provides care for individuals who are non-ambulatory, nonverbal, hearing impaired, and blind as well as those who have dementia, brittle bones, and suffer from seizures. Bland Tr. 883:18-884:4. First Step provides care to individuals who need 24-hour direct care, 24-hour nursing care, feeding tubes, and texture diets. Bland Tr. 883:18-884:4.

236. ICM provides services to individuals with developmental disabilities who have brittle bones, special positioning needs, dysphagia, extensive seizures, feeding tubes, modified texture diets, and ventilators. Alberding Tr. 1347:22-1351:12. ICM serves individuals who need resuscitation regularly and/or 24-hour direct care as well as individuals who are nonverbal, non-ambulatory and/or have visual and auditory impairments. Alberding Tr. 1347:22-1351:12.

237. Bost provides services to individuals who are non-ambulatory, nonverbal, ventilator dependent, hearing impaired, and/or blind. Lambert Tr. 1871:13-1874:16. Bost serves individuals who need 24-hour direct care, 24-hour on-call nursing services, feeding tubes, modified texture diets, and special positioning. Lambert Tr. 1871:13-1874:16. Bost serves individuals who have dysphagia, dementia, brittles bones, and extensive seizures. Lambert Tr. 1871:13-1874:16.

238. ASN serves adults and children with developmental disabilities who have severe medical needs and are medically fragile. Vire Tr. 1512:19-1515:18. ASN provides services to individuals who are non-ambulatory and nonverbal, as well as those who require 24-hour direct care, 24-hour nursing care, feeding tubes, modified texture diets, and special positioning. Vire Tr. 1512:19-1515:18. ASN serves individuals who have frequent seizures. Vire Tr. 1512:19-1515:18.

v. CHDC Individual Program Plans Fail To Provide Specific Information Regarding What an Individual Would Need To Transfer out of CHDC.

239. CHDC IPPs fail to provide a description of what a resident actually needs to live in an integrated setting, beyond a generic list of services. Richardson Tr. 529:2-9, 550:5-551:11. Even when IPPs have useful information, there is no application of this information that would

assist the team, resident, or guardian with understanding how the resident could move to an appropriate, more integrated setting. Richardson Tr. 580:20-581:5.

240. Most CHDC plans do not include, for example, specifically what type of specialized medical care or behavioral health intervention the individual would need, what kind of specialist would be required, or what type of and how often transportation might be necessary. Richardson Tr. 550:7-24, 551:1-11 (testifying that one would expect to see these elements in a program plan).

241. CHDC staff corroborated this assessment. CHDC program coordinator Donna Clendenin testified that CHDC IPPs do not identify the specific barriers to a resident's placement in a more integrated setting and do not provide a plan to overcome those barriers. Clendenin Tr. 1608:3-1609:10.

242. CHDC program coordinator Sarah Murphy also stated that CHDC residents' IPPs do not identify the extent to which a person needs any given service. Murphy Tr. 483:16-484:7, 486:13-487:14.

243. Furthermore, program coordinator Donna Clendenin testified that CHDC program coordinators do not contact community providers to determine whether they are able to provide services that meet the specific needs of an individual. Clendenin Tr. 1608:3-1612:22, 1610:19-1612:22; 1614:17-1616:2.

244. CHDC guardian Mr. Barry Landen testified that CHDC has never discussed a specific facility or placement with him. Landen Tr. 6858:3-10.

vi. CHDC Discharge/Transition Plans Fail To Identify the Specific Supports and Services an Individual Would Need in the Community or Describe Community Placement Options.

245. IPPs fail to describe the community options available to an individual or identify the specific supports and services the individual would need in the community. Richardson Tr. 580:18-581:5, 581:23-582:11.

246. Instead, each IPP only contains a generic transition plan that includes a "canned" list of general services the individual might need in the community such as medical care, dental services, occupational therapy, physical therapy, and/or speech therapy. Richardson Tr. 550:5-15; Bland Tr. 882:8-17 (redacted CHDC IPPs are repetitive); Vire Tr. 1527:2-10 (IPPs "seemed to be a template"); Alberding Tr. 1370:4-14 (transition plan sections of IPPs are a "canned" list of what teams conclude residents need); *see also* US FOF ## 79, 80, and 82 (CHDC program plans must be individualized).

247. The repetition and lack of individualization in CHDC IPPs are self-evident. Further review of individual plans demonstrates that they generally repeat the same, often identical, discharge services. Richardson 529:2-9; US FOF ## 248-263. Of the 15 discharge/transition service plans described below, all 15 require "direct care/supervision (24-hour basis)," access to emergency care, medical services, dietary services, dental services, day programming, transportation, and recreation/leisure services. US FOF ## 248-262. Eleven plans require a communication facilitator. US FOF ## 249-252, 255-261. Nine require psychiatric services. US FOF ## 249, 250, 253, 254, 257-261. Seven require "work sites/situations." US FOF ## 248, 251-255, and 257. Not 1 of the 15 plans has a discharge service requirement that is unique to that person. US FOF ## 248-262.

248. For example, the discharge services described for CHDC residents JN and RW are exactly the same. US Exs. 134-2 at 10, 178-2 at 12; Murphy Tr. 488:22-489:3, 490:5-12.

249. The discharge/transition plan of ET's IPP states that for discharge to be appropriate for him, the following services should be available: "[D]irect care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; behavioral intervention; communication facilitator; day programming; transportation; and recreation/leisure services." US Ex. 127 at 10; Richardson Tr. 558:19-25 (ET's plan is "generic.").

250. KF's discharge/transition plan states that her discharge needs are "direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary, and psychiatric services; behavioral intervention; communication facilitator; training/day programming; transportation; and recreation/leisure services." US Ex. 148 at 13; Richardson Tr. 561:1-5 (noting that list of discharge services needed is generic).

251. MD's discharge/transition plan states the following: "For discharge to be appropriate the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental and dietary services; communication facilitator; day programming/training; work sites/situations; transportation and recreation leisure services." US Ex. 162 at 13.

252. RD's discharge/transition plan states, "for discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental and dietary services; communication facilitator; day programming training; work sites/situations; transportation; and recreation leisure services." US Ex. 179 at 10.

253. LR's IPP discharge/transition plan states, "for discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; training/day programming; transportation; behavioral intervention and recreation leisure services." US Ex. 149 at 11-12.

254. JR's IPP discharge/transition plan states that the following services should be available if he is discharged: "direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; day programming/training; work sites/situations; transportation; and recreation/leisure services." US Ex. 135 at 11.

255. WF's program plan states, "for discharge to be appropriate for [WF] the following services should be available: direct care/supervision (24-hour basis); immediate access to emergency care; specialized medical, dental, and dietary services; communication facilitator; work sites/situations; training/day programming; transportation (wheelchair accessible); and recreation leisure services." US Ex. 199 at 11.

256. TR's discharge/transition plan lists the services he needs if discharge is to be considered by his IDT: "For discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, and dietary services; communication facilitator; day programming; transportation and recreation/leisure services." US Ex. 193 at 10.

257. DG's IPP transition plan states that "for discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, psychiatric and dietary services; behavioral

intervention; communication facilitator; training/day programming; work sites/situations; transportation; and recreation/leisure services." US Ex. 124 at 11.

258. DB's IPP states, "for discharge to be appropriate, the following services should be available: direct care/supervision (24-hour basis), immediate access to emergency care, specialized medical, dental, dietary, and psychiatric services, communication facilitator for consistency, day programming, transportation, and recreation/leisure services." US Ex. 566-21 at CON-US-0149254.

259. MB's IPP states that for discharge to be appropriate, the following services should be available: "direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary, and psychiatric services; behavioral intervention; communication facilitator; training day programming; transportation; and recreation/leisure services. US Ex. 562-3 at 11.

260. GB's IPP's discharge/transition plan states, "for discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary, and psychiatric services; behavioral intervention; communication facilitator; day programming; transportation; and recreation/leisure services." US Ex. 563-34 at 11-12.

261. CW's IPP states "for discharge to be appropriate, the following services should be available: direct care/supervision (24 hour basis); immediate access to emergency care; specialized medical, dental, dietary and psychiatric services; communication facilitator; day programming; transportation and recreation/leisure services." US Ex. 579-15 at 12.

262. SLA's transition/discharge plan lists her needs as "24-hour direct care supervision and assistance; specialized medical/dental services; specialized nutritional services, eating equipment

and G-tube feeding equipment; habilitation training; psychiatric services and behavioral intervention; therapies (PT); recreation and leisure services; specialized transportation and accessibility." US Ex. 18 at 12.

263. Most, if not all, of the CHDC IPPs are like the examples above and have the same or similar generic list of required discharge services. Richardson Tr. 550:5-8; Bland 882:8-17; Vire Tr. 1527:2-10; Alberding Tr. 1370:4-14; US Exs. 105 at 9 (IPP for AN), 112 at 14 (IPP for BR), 119 at 13 (IPP for CG), 121 at 12 (IPP for CA), 122 at 12 (IPP for DWB), 126 at 11-12 (IPP for EN), 138 at 14 (IPP for JM), 143 at 12 (IPP for JW), 167 at 11 (IPP for OM), 173 at 10-11 (IPP for RC), 179 at 10 (IPP for RD), US Ex. 184 at 12 (IPP for SLA), Richardson Tr. 581: 20-22 (SLA's plan is generic and not individualized); U.S. Exs. 186 at 10 (IPP for SH), 191-2 at 18 (IPP for TC), 194 at 17 (IPP for TH), 206 at 15 (IPP for ZS), 132 at 15 (IPP for HB), 561-21 at 13 (IPP for SA), 578-40 at 9 (IPP for MS), 580-9 at 8 (IPP for LW); *see also* US Exs. 101-1 at 15, 103-1 at 16, 111-1 at 15-16, 113-1 at 10, 114-1 at 10, 118-1 at 13, 129-1 at 9, 131-1 at 11-12, 136-1 at 14, 137-1 at 14, 139-1 at 11, 140-1 at 9, 146-1 at 9, 152-1 at 9-10, 156-1 at 12-13, 157-1 at 12-13, 163-1 at 16, 164-1 at 18, 165-1 at 12, 171-1 at 10, 172-1 at 14, 175-1 at 10, 180-1 at 13, 185-1 at 11, 187-1 at 11, 192-1 at 12-13, 196-1 at 12, 198-1 at 11-12, 200-1 at 11 (redacted IPPs).

264. CHDC staff admit that the IPPs contain stock language and that CHDC plans are repetitive. CHDC program coordinator Donna Clendenin conceded that CHDC IPPs contain stock transition planning language laying out only the broad services an individual would require to live in the community. Clendenin Tr. 1608:3-1612:22.

265. CHDC program coordinator Sarah Murphy testified that CHDC IPPs repeat generic activities as "significant needs" across several clients. Murphy Tr. 492:16-493:2, 498:20-499:10; US Exs. 134-2, 178-2, and 202-2.

266. Ms. Murphy also recognized that many of the services listed as discharge needs are services that every individual needs, whether the person has a developmental disability or not. Murphy Tr. 488:21-489:21 (agreeing that everybody needs emergency care, dental care, dietary care, medical care, transportation, work and leisure); US Ex. 178-2.

vii. CHDC Fails To Annually Re-Assess Residents' Discharge/Transition Plans.

267. CHDC policy requires treatment teams to evaluate annually each individual's eligibility for CHDC, including whether the individual's needs could be met in a more integrated setting. Defs. Ex. 912 at 170 (DDS Policy 1086); *see also Porter v. Knickrehm*, 457 F.3d 794, 797 (8th Cir. 2005).

268. CHDC fails to conduct this assessment in some cases and instead simply uses the same discharge/transition plan from year to year. *See* US FOF ## 79, 80, and 82 (responsibilities of IDT and annual review meeting). This is further evidence that CHDC program plans are generic and formulaic. Richardson Tr. 529:2-9. It also demonstrates that CHDC teams fail to find or plan for more integrated settings for CHDC residents. Richardson Tr. 572:1-9; US Exs. 143 and 143-2.

269. For example, 22 year-old JW's 2008 transition/discharge plan is identical to his 2009 transition/discharge plan. Richardson Tr. 571:17-25; US Exs. 143 at 12, 143-2 at 14. Although JW's guardian expressed some interest in a more integrated setting, US Ex. 272, CHDC has

failed to make any active effort to find such a setting or create a plan for placement for him. Richardson Tr. 572:1-9; US Exs. 143, 143-2.

270. Similarly, there is no difference between ten year-old T.C.'s 2007 and 2008 discharge/transition plans. Richardson Tr. 568:21-23; US Exs. 191 at 17, and 191-2 at 17. This is particularly concerning because of the destructive effects of childhood institutionalization and the risks of long term institutionalization. Richardson Tr. 548:5-17, 568:24-569:3; US Exs. 191 at 18, 191-2 at 17; *see* US FOF ## 34-37 (expert Matson testimony regarding effects of childhood institutionalization).

271. TC's IPP states that his behavior was improving, and that an improvement in behavior was required for discharge. US Ex. 191-2 at 3, 18. It also states that his grandmother is considering taking care of him. US Exs. 191 at 17, 191-2 at 17. Despite these significant changes in TC's circumstances, his IPP was unchanged. Richardson Tr. 568:21-23; US Exs. 191 at 17, 191-2 at 18. It does not state what is being done to prepare supports for his grandmother so that an eventual discharge could be successful. Richardson Tr. 563: 9-16; US Ex. 191-2 at 3, 18.

272. RC is a 15-year-old female. She was admitted to CHDC at the age of 12 and is in the custody of the Division of Child and Family Services. US Exs. 181, 181-2. Her 2008 and 2009 transition plans are identical. US Exs. 181, 181-2; Clendenin Tr. 1633:12-1636:4. Her IPP lists her as having a mild intellectual disability. US Ex. at 181-2.

273. RW is a 48-year-old male who has resided at CHDC since he was 10 years old. US Exs. 178, 178-2. Despite assertions that IPPs became more detailed between 2009 and 2010, RW's discharge/transition plan remained identical during those years. US Exs. 178, 178-2; Clendenin Tr. 1598:15-1602:11.

viii. CHDC Interdisciplinary Teams Identify Long Range Goals and Significant Needs in CHDC Individual Program Plans That Are Biased Towards Continued Institutionalization.

274. CHDC IPPs also fail to prepare individual residents for discharge by establishing long range goals or significant needs for residents that are not individualized and act as barriers to consideration for a more integrated setting. Richardson Tr. 585:4-11, 610:20-611:1.

275. CHDC IPPs long range goals are not geared toward individuals' eventual independence and/or discharge, despite CHDC's policy that "increased competence/independence in successfully less restrictive settings" is the "foundation for all decisions regarding services" and "[t]he annual review is driven by th[is] belief." US FOF ## 79, 80, 82 (requirements of CHDC IPP policy).

276. For example, many CHDC IPPs contain similar long range goals that indicate, both explicitly and implicitly, that the individual resident will remain at CHDC. US FOF ## 277-287.

277. "By 2015 I will continue to reside at CHDC." US Ex. 178-2 at 13 (IPP for RW).

278. "By 2012, I will have the social self-help and daily living skills enabling me to function more independently in my present residence." US Ex. 124 at 13 (IPP for DG).

279. "By 2012, I will have the self-help and daily living skills enabling me to function more independently in my present residence." US Ex. 127 at 12 (IPP for ET).

280. "I will establish greater independence in daily living and person hygiene in order to function more effectively in my home at CHDC during the next 5 years." US Ex. 138 at 17 (IPP for JM).

281. "I will maintain my physical/cognitive skills allowing me to work ¾ of a day in jobs on campus". US Ex. 162 at 15 (IPP for MD).

282. "By 2012, I want to be employed at an on campus job to make spending money." US Ex. 173 at 13 (IPP for RC).

283. "By 2012 I will have self-care and daily living skills enabling me to function more independently in my present residence." US Ex. 179 at 12 (IPP for RD).

284. "I will establish greater independence in daily living and personal hygiene in order to function more effectively in my home at CHDC during the next 5 years." US Ex. 195 at 18 (IPP for TN).

285. "By 2012, I will have communication, self-help, and daily living skills enabling me to function as independently as possible in my present residence." US Ex. 199 at 13 (IPP for WF).

286. "By 2012, I will learn appropriate behaviors in order to function more independently in his [sic] environment at CHDC and home visits." US Ex. 206 at 17 (IPP for ZS).

287. "By 2012 I will have self-help and daily living skills enabling me to function independently in my present residence." US Ex. 135 at 13 (IPP for JR); *accord* US Exs. 112 at 15 (IPP for BR), 115 at 16 (IPP for CL), 119 at 14 (IPP for CG), 134-2 at 15 (IPP for JN), 142 at 14 (IPP for JB), 143 at 14 (IPP for JW), 161 at 17 (IPP for MF), 561-21 at 14 (IPP for SA), 563-34 at 14 (IPP for GB), 579-15 at 14 (IPP for CW); *see also* US Exs. 101-1 at 17; 103-1 at 18; 114-1 at 12; 118-1 at 14; 140-1 at 11; 156-1 at 15; 163-1 at 18; 165-1 at 15; 171-1 at 12; 177-1 at 17; 180-1 at 15; 185-1 at 13; 200-1 at 13 (Redacted IPPs).

288. Other CHDC individual program plans contain boilerplate goals that are impersonal, not individualized, and are not needs that require continuing institutionalization. Richardson Tr. 582:17-583:4, 610:20-611:1; US Ex. 184 at 14.

289. For example, SLA's IPP lists her long range goals as having three self-help skills by 2013 and identifying 6 functional items by 2012. *Id.* In assessing these goals, expert Toni Richardson stated:

> Well, for the year 2013, her long-range goal is to have three self-care skills independently. That's – that certainly might be a goal, but is that the important goal for this person? Are there goals around making friends, having contacts in her community? Those are the kind of things I would look for in personal long-range goals, something that was really going to make her life more meaningful, because, in my experience, self-care skills, while important and while you want to work on them, I don't think most people want to spend a lifetime on tooth brushing or pulling on their shirt or whatever, combing their hair. And it's one of those skills that if you can teach it to the person, teach it; if you can't, work around it, in my way of thinking.

Richardson Tr. 582:16-583:4; *see also* US Exs. 186 at 12 (IPP for SH), 121 at 13 (IPP for CA), 132 at 17 (IPP for HB), 149 at 14 (IPP for LR), 153 at 21 (IPP for LW), 146-1 at 12, 160 at 17 (IPP for ME), 191 at 19 (2007 IPP for TC), 191-2 at 19 (2008 IPP for TC), 562-3 at 13 (IPP for MB), 184 at 14 (IPP for SLA), 202-2 at 14 (IPP for WC), 101-1 at 17, 113-1 at 13, 129-1 at 11, 131-1 at 14, 136-1 at 17, 139-1 at 13, 167-1 at 15, 172-1 at 16, 187-1 at 13 (redacted IPPs).

290. The community services providers who reviewed redacted CHDC IPPs noted that CHDC IPPs long range goals were not geared toward individuals' eventual independence and/or discharge. *See* US FOF ## 79, 80, 82 (requirements of CHDC IPP policy).

291. For example, when discussing US Ex. 163-1 (redacted IPP), community provider Pam Bland of First Step testified that she was unsure as to what outcome the interdisciplinary team sought to achieve through the long range goals. Bland Tr. 880:6-24 ("If that person acquires those social behaviors that allow them to follow a daily routine, what would the outcome be? Would the outcome be that they are back at home, back in the community, back in the public school?"). Provider Bland testified that "an overall goal for a person with these skills is for them to live independently in a group home or in their own apartment and have a job." Bland Tr.

881:11-15; US Ex. 148-1 at 14 (skills include naming shapes, cutting with scissors, reading/writing the alphabet and ability to print name).

292. Community services provider ICM could serve an individual whose long term goal was inappropriately geared toward CHDC, and not toward a more independent community setting. Alberding Tr 1360:7-1362:20; US Ex. 156-1 at 15 (long range goals listed as: "By 2012, I will expand my skills in discrimination/identifying items in order to function more effectively in my home at CHDC. By 2012, I will expand my self-help skills in order to function more effectively in my home at CHDC."); *see also* Vire Tr. 1533:14-1536:14 (individual in question has the long range goal of remaining at CHDC); US Ex. 143-1 at 14 ("I will perform activities of daily living on a level that will allow me to function more independently in my living environment during the next 3-5 years.").

293. When CHDC interdisciplinary teams include objectives such as tooth brushing and money management in CHDC program plans, they neglect goals that make an individual resident's life "more personal, more normal, less restrictive, more integrated . . . life isn't all about skill programs." Richardson Tr. 698:10-21, 583:8-13 ("reading the plans and looking at the policy, it looks like people generally are asked to find a goal in money management. I think every single person I read had a goal in money management or around medication administration. Everybody had some kind of a goal around medication administration, whether it looked like they really had some potential to do it or some interest in doing it.").

294. Further examples include the IPP of TN which lists participating in a gardening activity, identifying five colors, and holding money for 60 seconds among his significant needs. Weaver Tr. 392:4-392:20; US Ex. 160.

295. The interdisciplinary team for CHDC resident ZS, identified organizing his closet, making his bed, identifying combinations of coins, and matching textures as some of his significant needs. Weaver Tr. 393:6-393:11, 396:11-397:2; US Exs. 206, JW-3.

296. The interdisciplinary team for CHDC resident JN identified his significant needs as performing a laundry task more independently, weighing paper on a scale, working for long periods without stopping, returning to work after a distraction, matching coins, and tearing perforated paper more independently, among others. Murphy Tr. 484:11-484:22; US Ex. 134-2.

297. The interdisciplinary team for WC identified some of his significant needs as weighing paper on a scale, arriving to work on time, and improving his teeth-brushing skills. Murphy Tr. 494:14-23; US Ex. 202-2.

298. RD's IPP lists significant needs such as "wash hands independently" and "match coins." US Ex. 179 at 12.

F. Defendants' Failure To Provide Objective, Reasonable Assessments Deprives Individuals and Guardians of Information Sufficient To Make Informed Choices About Community Placement.

299. Without the benefit of an independent, objective assessment based on the individual's needs, individuals and their guardians are denied sufficient information about the resources, possibilities, and benefits associated with a more integrated setting. Richardson Tr. 555:21-556:7; *see also* US FOF ## 79, 82 (CHDC program plans should be specific to an individuals' long range goals, behavioral objectives, and service objectives and should address how these objectives can be achieved in the least restrictive environment.).

300. Only with an objective, reasonable assessment, and an opportunity to discuss particular alternatives to continued institutionalization based on the individual's strengths and needs, can

residents or guardians make an informed choice as to whether they wish to pursue a more integrated setting or not. Richardson Tr. 618:1-6.

301. When the individuals who work with residents every day are not informed regarding the supports and services available in the community and the potential benefits of a more integrated environment, then guardians and residents are apt to walk away with an inaccurate impression of what the life of their loved one would be like in a more integrated setting. Richardson Tr. 616:23-617:13, 618:1-6.

302. Guardians and residents who have experienced long term residential care are often reticent regarding the possibility of placement in a more integrated setting. Richardson Tr. 608:19-22. However, they are also positive about placement in a more integrated setting once they have that experience. Richardson Tr. 608:19-609:5; *see* Richardson Tr. 609:6-10 (research supports this conclusion).

303. When individuals and their guardians do not have information about what options are available and what is possible, then they are unlikely to state that they would like to try a more integrated setting than CHDC. Richardson Tr. 608:9-18, 617:22-618:4 (Residents, guardians and decision-makers "need a good, solid objective view. Even though it might be painful to hear because they don't want to think about leaving, it's important that they know what well-informed professionals think is possible."); *see also* Richardson Tr. 616:23-617:13 (noting that guardians rely on staff for information about the day-to-day life of residents).

304. Before ever attending the annual review or receiving any assessment or recommendation from the IDT regarding whether their loved one is appropriate for a more integrated setting, CHDC guardians are required to complete a "choice form," on which they identify whether they are seeking waiver services or HDC services. Defs Ex. 406 (Choice Form); A. Green Tr.

6777:24-6778:8, 6800:1-9. Prior to being asked to designate their choice on this form, the only information guardians receive is a list of nearby community providers and the services they provide, and a general informational packet about the Waiver process. Murphy Tr. 501:15-502:17. CHDC social service workers do not discuss with guardians what waiver services are until after they have made their choice between HDC or waiver services. Green Tr. 6799:3-6800:8.

305. Furthermore, CHDC social worker supervisor Angela Green also admitted that "as CHDC is notified of vacancies in alternative placements close to family/guardian, they'll inform the residents, families of the vacancy. When interest is expressed, the resident, family, or guardian are encouraged to tour and talk with staff at the placement." A. Green Tr. 838:11-17; Richardson Tr. 556:17-21; US Ex. 264.

306. CHDC's five team leaders confirmed that CHDC does not talk to its residents and families about waiver except to let them know that waiver exists. Richardson Tr. 555:23-556:7.

307. Testimony from CHDC parents and guardians confirms that they are not properly informed regarding community placement and more integrated settings appropriate for CHDC residents. CHDC guardian Michael Black testified that CHDC teams have mentioned the waiver option but did not explain to him specific services like EPSDT and wrap-around services. M. Black Tr. 6830:21-23 ("Q. Does CHDC speak to you about waiver options at the IPP meeting? A: They mention them, yes."), 6838:1-11. As a result, Mr. Black did not know of any alternate placements because it was his understanding that "there aren't any." M. Black Tr. 6840:3-14.

308. Mr. Black stated that if an alternate placement was available, he would consider it. M. Black Tr. 6840:11-14.

309. CHDC guardian Larry Taylor testified that he would love to see [C] "in a little home in Hillcrest" but that his belief is that "it's not going to happen." L. Taylor Tr. 5075:11-14; *see* US FOF # 117 (Community providers can provide services for majority of individuals at CHDC).

310. CHDC guardian Earline Stoddard testified that CHDC did not tell her that community service providers offered total care. E. Stoddard Tr. 3254:5-8; *see* US FOF # 232 (CHDC guardian testified that CHDC never discussed specific facility or placement).

311. CHDC annual review meetings, which provide an opportunity for team members, residents, and guardians to discuss the assessments memorialized in the IPP, provide little or no discussion of the most integrated setting unless such discussion is requested by the guardian. Richardson Tr. 549:11-18. The IDT teams, observed by expert Richardson during two annual review meetings, mentioned the waiver program and referenced community life but did not actually discuss the barriers to placement in a more integrated setting or how the individual resident could benefit from placement in a more integrated setting. Richardson Tr. 607:1-12; *see* Richardson Tr. 549:11-18.

312. In one annual review, expert Richardson observed that the discussion of community options was brief and almost apologetic. Richardson Tr. 549:15-550:4 ("I know we have to talk about this again this year, but . . . ."). In the other meeting, when the CHDC resident was asked for his input, he stated, "I would like to get a home," but the rest of the meeting focused on why he was going to remain at CHDC. Richardson Tr. 549:15-550:-4. The team added that "if you behave and if you learn your skills, then maybe someday we'll be able to find a home for you." Richardson Tr. 550:1-4; *see* US FOF ## 225-228 (CHDC's use of behavioral improvement as a barrier to community placement).

313. Absent discussion about the possibilities and benefits of placement in a more integrated setting, guardians are not given appropriate information about what may be possible for each individual. Richardson Tr. 607:15-17 ("I don't know how else you decide what the least restrictive, most integrated setting would be for somebody unless you talk about what would be possible.").

314. Defense psychiatric consultant Andrew Warren sat in on one annual IPP meeting. He described the way the team addressed community placement issues with the guardian as "I think it was mentioned that we have to say this to you . . . .". Warren Tr.4810:14-4811:8. He saw no indication of an independent professional assessment about community placement. Warren Tr.4810:14-4811:8.

315. Erline Stoddard is the mother and guardian of a longtime CHDC resident. Stoddard Tr. 3230:17-25-3231:1. Ms. Stoddard testified that at her son's annual IPP reviews, the IDT does not provide her with information about providers that offer the specific services her son would need to be supported in the community, Stoddard Tr. 3253:5-3254:8, 3259:7-12, nor does the IDT make a recommendation regarding the most integrated setting appropriate to her son's needs, once Ms. Stoddard informs them she is not interested in pursuing community placement. Stoddard Tr. 3243:8-10.

316. Larry Taylor, guardian of a longtime CHDC resident, testified that the discussion of community placement options for his sister at her annual reviews consists of the IDT asking him, "do you think [C] would be happier somewhere else? Do you want to explore other options?" L. Taylor Tr. 5075:3-10.

317. Barry Landon is the brother and guardian of a longtime CHDC resident. He testified that the IDT asks him during annual reviews if he would like to discuss waiver options and that when

he says, "no," that is the end of the discussion regarding his brother's appropriateness for a more integrated setting. Landon Tr. 6857:19-6858:2. Nevertheless, Mr. Landon's brother is capable of regular home visits in Mr. Landon's home and has never experienced an emergency or major problem during these visits. Landon Tr. 6860:3-9. The IDT does not raise particular placement options with Mr. Landon, Landon Tr. 6858:3-10, even though Mr. Landon testified that such information would be useful and he would want to have it. Landon Tr. 6861:6-19.

III. CONCLUSIONS OF LAW– VIOLATIONS OF THE AMERICANS WITH DISABILITIES ACT

A. The ADA Requires Defendants to Provide CHDC Residents with Objective, Reasonable Assessments Regarding Whether They Are Appropriate for a More Integrated Setting.

Defendants are discriminating against individuals at CHDC by failing to ensure that they are serving them in the most integrated setting appropriate to their needs, in violation of the ADA. Congress enacted the ADA "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," and "to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for [individuals with disabilities]." 42 U.S.C. § 12101(a)(7) and (b)(1). In doing so, Congress emphasized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2).

Title II of the ADA prohibits discrimination in access to public services by requiring that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The ADA implementing regulations include an "integration mandate." *See* 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."). The regulations define the most integrated setting as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. pt. 35 app. A.

In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court held that unjustified segregation of persons with disabilities in institutions like CHDC constitutes the type of discrimination Title II of the ADA prohibits. In doing so, the Court emphasized that when Congress enacted the ADA, it explicitly recognized as a form of discrimination the "unjustified 'segregation' of persons with disabilities." *Id.* at 600. The Court reasoned that this recognition reflected two judgments by Congress about the serious harm that unnecessary isolation causes individuals:

> First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

Id. at 600-01 (citations omitted). In construing the integration mandate, the Court held that a violation is established if the institutionalized individual is "qualified" for community placement, that is, if he or she can "handle or benefit from community settings" and does not oppose community placement. *Olmstead*, 527 U.S. at 601-03.[2]

In *Olmstead*, the plaintiffs were two institutionalized individuals who wanted to move to the community and whose treating professionals agreed that community placement was appropriate. *Id.* at 602-03. Thus, the fact that the plaintiffs were "qualified" for a more integrated setting was not in dispute. *Id.* In the context of the facts before it, the Court acknowledged that a state could generally rely on "the *reasonable* assessments of its own

[2] The state, however, may assert an affirmative defense that serving a particular individual in the most integrated setting would "entail a 'fundamenta[l] alter[ation]' of [its] services and programs." *Id.* at 603 (plurality opinion) (first two alterations in original).

professionals" to determine "whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program." *Id.* at 602 (emphasis added).

Subsequent cases have emphasized, however, that "*Olmstead* does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities." *Frederick L. v. Dep't of Pub. Welfare*, 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001); *Long v. Benson*, No. 08cv26, 2008 WL 4571904, at *2 (N.D. Fla. Oct. 14, 2008) (noting that the State "cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community"); *see also Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 259 (E.D.N.Y. 2009) (recognizing that violations of the ADA's integration mandate are not limited to where the State's own professionals have determined an individual is appropriate for a more integrated setting); *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 291 (E.D.N.Y. 2008) (same). Such perverse results would render the integration mandate virtually meaningless. Therefore, for a public entity, such as CHDC, to aver that it is "administer[ing] services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities," 28 C.F.R. § 35.130(d), it must provide an objective, reasonable assessment of whether the individual can "handle or benefit from community settings." *Olmstead*, 527 U.S. 601-02.

An assessment is not an objective determination of an individual's capability of residing in a more integrated setting if it is only conducted when an individual or guardian affirmatively seeks community services. *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 329, 338 (D. Conn. 2008) (rejecting the notion that an assessment of individuals' appropriateness for community placements is required only in those cases "in which a class member, a parent, or a

guardian has explicitly asked for community placement" and finding that "[s]uch an attitude is inconsistent with the integration mandate of the ADA."). Nor should clinical assessments of whether an individual could be supported in a more integrated setting be limited to consideration of what is currently available in the community. *Id.* at 330 (IDTs should consider community placement for residents "'without consideration of availability of resources.'") (quoting testimony of defense consultant Dr. Walsh); *see also* US FOF ## 85 (Defendants' consultant Kastner testifying that a treatment team's determination regarding the most appropriate setting for a resident should be separate from the guardian's decision about placement), 86 (Defendants' consultant Walsh testifying that availability of services should not be a bar to a recommendation for community placement).

Rather, an objective, reasonable assessment must be based on the individual's needs and consideration of the services necessary to meet those needs. An individual must be provided the option of a particular alternative to continued institutionalization based on an objective, reasonable assessment. 28 C.F.R. pt. 35, app. A ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."); *Messier*, 562 F. Supp. 2d at 338 (The ADA "regulations do not conceive of a resident's option to decline community placement as a right that is to be exercised before any professional judgment has been brought to bear. Rather, the regulations state that 'persons with disabilities must be provided the option of declining to accept a *particular* accommodation.'").

B. Defendants Discriminate Against Individuals at CHDC By Depriving Them Objective, Reasonable Assessments Regarding Whether They Are Appropriate for a More Integrated Setting.

CHDC interdisciplinary teams discriminate against individuals at CHDC by failing to provide individuals and their guardians with objective, reasonable assessments of whether they can live in a more integrated setting, in violation of the ADA. 42 U.S.C. §§ 12101-12213; 28 C.F.R. § 35.130(d); *Olmstead*, 527 U.S. at 602. Instead, CHDC treatment teams routinely conclude that CHDC is the most integrated setting for individuals, except when a guardian proactively – but without the benefit of an independent assessment and recommendation – requests community placement. In this way, individuals and their guardians are deprived of the benefit of an independent judgment about the resident's appropriateness for a more integrated setting, including the opportunity to meaningfully discuss what services and supports the individual would receive in the community.

CHDC's failure to provide objective, reasonable assessments harms CHDC residents both individually and systemically. As discussed in Section C below, CHDC deprives individual residents and guardians of the benefit of the treating professionals' objective, reasonable assessment of whether the resident could handle or benefit from community placement, including the opportunity to meaningfully discuss what services and supports the individual would receive in the community. *See also* US FOF # # 91-317. This encourages individual guardians to maintain the *status quo* of continued institutionalization, the setting in which their loved ones already receive services and with which the guardians are most familiar. *See Messier*, 562 F. Supp. 2d at 333; US FOF ## 303-305.

Additionally, so long as CHDC does not assess individuals to determine what supports and services they would need to be supported in the community, community providers cannot

develop the capacity, and tailor the services they provide, to meet the needs of those currently institutionalized. *Messier*, 562 F. Supp. 2d at 339 ("Having failed to learn how many class members could or should be placed in the community, the defendants failed to develop resources for placing class members."); US FOF ## 89, 186.

The harmful, discriminatory effects of CHDC's failure to conduct objective, reasonable assessments of residents are reflected by the extreme length of stay for most individuals at CHDC, the increasing number of children being admitted to CHDC, and how few individuals are ever discharged from CHDC. US FOF ## 23-33. In fact, more individuals die at CHDC than are discharged. US FOF # 29. By failing to conduct objective, reasonable assessments, CHDC ensures the perpetuation of a discriminatory and unlawful method of delivering services to individuals with developmental disabilities, where institutionalization is the default option, in violation of the ADA. 28 C.F.R. § 35.130(d) (the ADA mandates that public entities "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); *Messier*, 562 F. Supp. 2d at 337 ("The ADA's preference for integrated settings is not consistent with a procedure in which remaining [institutionalized] is the default option for residents.").

1) CHDC Teams Fail To Find That Any Residents Can Be Served in More Integrated Settings Unless a Guardian Affirmatively Requests Or Expresses Interest in Community Placement.

CHDC treatment teams fail to conduct independent clinical assessments of individuals and, instead, routinely conclude that CHDC is the least restrictive setting appropriate for individuals unless a guardian has affirmatively requested or otherwise expressed an interest in community placement. Indeed, the only four individuals that CHDC identified at the time of the

trial as having their IDTs determine that they were appropriate for a more integrated setting were the same four individuals that CHDC identified as having expressed an interest in community placement. US FOF # 93. In other words, CHDC IDTs did not conclude that a single resident is appropriate for a more integrated setting – except for those whose guardians had already requested community placement. Additionally, longtime CHDC staff testified that they could recall few, if any, instances where an IDT determined that an individual was appropriate for a more integrated setting when a guardian had not explicitly expressed interest in pursuing, or at least affirmatively supported, a more integrated setting. See US FOF ##105-113.

In stark contrast to CHDC's identification of only 4 of its over 500 residents – less than 1 percent of its total population – as appropriate for a more integrated setting, community service providers from throughout Arkansas confirmed that they can serve the overwhelming majority of the individuals described in the 46 sample IPPs they reviewed. US FOF ## 115-147. This is consistent with the testimony of the United States' expert, and further evidence that CHDC has abdicated its duty to conduct objective, reasonable assessments of individuals at CHDC in violation of the ADA. *Messier*, 562 F. Supp. 2d at 337-38; *Frederick L.*, 157 F. Supp. 2d at 540; *Long*, 2008 WL 4571904, at *2; *see* US FOF ## 92-99.

2) Treatment Teams at CHDC Do Not Have Sufficient Knowledge or Training About Community Integration to Make Reasonable Recommendations Regarding the Most Integrated Setting Appropriate for Individuals at CHDC.

CHDC interdisciplinary teams are composed of individuals who, by their own admissions, do not have sufficient knowledge or training regarding community services, options, and benefits. Therefore, they are incapable of providing objective, reasonable assessments, in violation of the ADA. CHDC team leaders, program coordinators, psychology staff, and even

the Superintendent and Director of Social Services, all have a profound lack of understanding about what services are available in the community, what skills an individual needs to be eligible for a community placement, and what benefits there are to community living. For example, the Director of Social Services is the CHDC staff member considered to be *most* knowledgeable about community placement services, as well as the person responsible for the training and supervision of the staff members who are directly responsible for providing community placement information to parents and families. US FOF ## 63-65. The Director is not familiar with all the services available in the community, was not even aware of the existence of a DDS waiver guide until April 2010 (when a community provider gave her a copy), and is unable to identify independently any benefits to living in settings more integrated than CHDC, other than being able to choose where one lives. US FOF ## 160-162.

Other staff members in leadership positions likewise have a pervasive lack of knowledge about community placement options for individuals residing at CHDC. US FOF ## 163-176. Many have never even visited a community placement setting in Arkansas, yet they are the staff members directly responsible for ensuring that individuals at CHDC are assessed to determine whether they are appropriate for a more integrated setting. US FOF ## 163-176.

3) Individual Program Plans Demonstrate CHDC's Failure to Conduct Objective, Reasonable Assessments of Whether Individuals Are Appropriate For A More Integrated Setting.

CHDC's individual program plans demonstrate CHDC's failure to provide objective, reasonable assessments to individuals at CHDC, as well as CHDC staff's lack of knowledge and training about community placement. A disturbingly large proportion of CHDC IPPs identify arbitrary barriers to community placement, such as the need to acquire routine daily living skills

or independent living skills. *See, e.g.*, US FOF ## 189-203. Yet community programs that currently exist in Arkansas provide training in self-care skills and independent living skills. *See* US FOF ## 115-147, 153-154 and 196-198. Therefore, as the community providers' testimony confirms, a lack of such skills does not disqualify an individual from eligibility for community placement, and should not be identified in an individual's plan as the reason he or she should continue to be deprived of the opportunity to live alongside of, and experience life with, non-disabled people. *See* US FOF ## 115-147, 153-154 and 196-198. Indeed, in some cases, an individual may never gain some basic daily living skills and yet could nevertheless be served in a more integrated setting. *See* US FOF ## 199-201.

Similarly, many CHDC IPPs contain inappropriate language requiring that individuals advance through the "team hierarchy" at CHDC before they can be considered for placement in a more integrated setting. US FOF ## 95, 143 and 204-214. This concept of requiring that individuals "earn" their way out of an institution is inconsistent with the ADA's mandate that individuals be served "in the most integrated setting appropriate to the needs of qualified individuals with disabilities," and results in the needless segregation of individuals with developmental disabilities. 28 C.F.R. § 35.130(d); *see also* US FOF # 204.

Individuals' behavioral and medical issues are also often listed in CHDC plans as a barrier to community placement. US FOF ## 215-238. Many plans condition consideration for a more integrated setting on an improvement in the individual's behavior. US FOF ## 215-228. But for some individuals, maladaptive behaviors are reactions to his or her environment, and may not occur if the person was living in a setting more tailored to his or her individual needs. US FOF ##215-220. This is particularly true for institutionalized children, who often observe and model the maladaptive behaviors that occur around them. US FOF ## 34-37 . In any case,

community programs that currently exist in Arkansas serve individuals with all sorts of behavioral health issues, including individuals who have aggressive behaviors, need 24-hour direct care, and lack good judgment regarding personal safety, and are not valid bases for depriving individuals of the opportunity to live in a more integrated setting. *See, e.g.*, US FOF ## 128, 130, 135, 137, 140, 142, 144, 146, 224-228.

Likewise, individuals with significant medical issues, for example, individuals who are non-ambulatory, nonverbal, hearing impaired, blind, and who have brittle bone disease, dementia, and seizures, are routinely served in more integrated settings than CHDC, including more integrated settings that currently exist in Arkansas. *See, e.g.*, US FOF ##138, 140, 142, 147, 229-238. The fact that so many IPPs at CHDC identify false barriers to community placement, such as those discussed above, demonstrates CHDC's failure to conduct reasonable assessments of individuals' appropriateness for more integrated settings as well as CHDC's staff members' inability to do so.

Additionally, IPPs are generic and formulaic, and reflect CHDC's overall discriminatory bias toward continued institutionalization and the absence of any meaningful efforts to transition individuals to the community. IPPs fail to describe what an individual would actually need to live in a more integrated setting, such as what type of specialized medical care or behavioral health intervention the individual would need, or the type of transportation that would be necessary. US FOF ## 239-266. Transition plans for individuals at CHDC are not individualized. Instead, plans include a "canned" list of general services an individual might need in the community, such as medical care, dental care, and/or 24-hour emergency care -- many of which are services to which *everyone* needs access, and not at all tailored to identifying what a specific individual at CHDC with particular disabilities would need to live successfully in

a more integrated setting. US FOF ## 245-266. Frequently, IDTs use the same discharge plan for an individual year after year, demonstrating that CHDC sets goals for discharge that individuals cannot meet and, indeed, are not expected to meet. US FOF ## 267-273.

Likewise, long term goals for individuals at CHDC reflect the lack of any expectation or goal that individuals move to more integrated settings. US FOF ## 277 ("By 2015, I will continue to reside at CHDC."), 279 ("By 2012, I will have the self-help and daily living skills enabling me to function more independently in my present residence."), and 284 ("I will establish greater independence in daily living and personal hygiene in order to function more effectively in my home at CHDC during the next 5 years."). Goals such as these reveal Defendants' discriminatory intent to preserve institutionalization as the "default option" for individuals at CHDC, in violation of the ADA. *Messier*, 562 F. Supp. 2d at 337; *see also Disability Advocates, Inc.*, 653 F. Supp. 2d at 259 (where State considers an institutional setting to be individuals' "permanent placements," a recommendation by State professionals that individuals are appropriate for community placement is not necessary to establish ADA violation).

C. Defendants' Failure To Provide Objective, Reasonable Assessments Deprives Individuals and Guardians of Information Sufficient To Make Informed Choices About Community Placement.

As a result of CHDC's failure to provide objective, reasonable assessments of individuals' appropriateness for a more integrated setting, individuals and guardians are deprived of information that is critical to their ability to make informed decisions regarding whether they wish to pursue community placement, or whether they would decline to accept a "particular accommodation." 28 C.F.R. pt. 35, app. A. In *Messier*, the court criticized the state for failing

to conduct community placement assessments of individuals whose guardians responded to a survey indicating that they wanted their ward to remain in the facility. 562 F. Supp. 2d at 333-34. The court explained that "neither the survey nor the cover letter gave much sense of what placement options were available. This might have encouraged respondents to 'play it safe' by indicating that they preferred their wards to remain at [the institution], the option with which they were most familiar." *Id.* at 333. The court also found that "efforts to educate guardians about community placement are often successful in changing their attitudes," and that "[a]n opportunity to discuss the possibility of community placement with guardians could make a substantial difference in the number of referrals for placement." *Id.* at 333, 338. Ultimately, the court held that, "[b]y concluding from the results of the Family Survey that there is no demand for community placements, the defendants may have prevented guardians and families from making informed choices." *Id.* at 338.

Like *Messier*, Defendants discriminate against individuals at CHDC by depriving them and their guardians of a professional recommendation regarding a particular alternative to continued institutionalization based on an objective, reasonable assessment of that individual, including the opportunity to meaningfully discuss that alternative. CHDC guardians are, at best, notified of the abstract right to pursue community placement, and then asked whether they are "happy" at CHDC or whether they are "interested" in further information about community placements. US FOF ## 305, 307-317. Indeed, CHDC guardians are asked to declare, in writing, a placement preference before the annual IPP review even occurs. US FOF # 304. Neither the IDT nor the individual's social service worker discusses with guardians what a waiver is in even general terms until *after* they have already made their choice between institution or waiver services. US FOF # 304.

Moreover, treatment teams do not assess or discuss in any particularized way a resident's appropriateness for a more integrated setting unless a guardian explicitly, without the benefit of an objective, reasonable assessment of the individual's appropriateness for a more integrated setting, expresses an interest in community placement. *See* US FOF ## 91-114, 305-317. Not coincidentally, the only residents that CHDC had identified at the time of trial as appropriate for a more integrated setting are the same four individuals whose guardians explicitly requested community placement. US FOF # 93.

This is not the scenario envisioned in the ADA's protection of an individual's right to decline to accept a "particular accommodation." 28 C.F.R. pt. 35, app. A. Although guardians of long term institutional residents are often initially hesitant regarding the possibility of a more integrated setting, they react more favorably to community placement once they have been provided with detailed information about community options and an opportunity to speak with community providers and visit community placements. US FOF ## 301-303; *see also Messier*, 562 F. Supp. 2d at 333 (describing expert testimony that "guardians of institutionalized wards are generally more likely to favor community placement when faced with concrete options for placement than when considering the abstract possibility that their ward could live in a more integrated setting"). By denying CHDC residents and their guardians information that is critical to their ability to make informed decisions about whether CHDC is the most integrated setting appropriate to residents' needs, Defendants safeguard a discriminatory system where CHDC remains the "default option" for its residents, in violation of the ADA's integration mandate. *See* 28 C.F.R. § 35.130(d).

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IV. FINDINGS OF FACT – PROTECTION FROM HARM

318. CHDC subjects residents to repeated harm, and unreasonable risk of harm, by failing to provide reasonably safe conditions for residents. Standard protection from harm systems include processes to identify individuals' risks of harm, respond to incidents of harm when they occur, and provide oversight of incident, injury, and staff abuse/neglect trends at an individual and systemic level, to try to prevent future harm to individuals. CHDC's systemic failures cause ongoing and repeated harm to residents from: CHDC's failure to intervene to address and prevent repeated injuries; CHDC's failure to address preventable self-injurious behaviors; CHDC's failure to prevent serious injuries such as fractures and lacerations from falls and other events that are preventable with adequate supervision and appropriate risk and incident management procedures; CHDC's failure to prevent dangerous exposure to bloodborne pathogens from other residents; staff abuse and neglect; and staff's inappropriate and excessive use of restraints. *See* FOF ## 319-376. As a result, CHDC's protection from harm practices substantially depart from generally accepted professional standards and violate residents' constitutional rights to reasonably safe conditions. Osgood Tr. 44:25-45:3, 46:7-47:11, 184:16-186:5.

A. Expert Carla Jo Osgood Provided Credible Expert Testimony That CHDC's Substantial Departure from Generally Accepted Minimum Professional Standards of Protection from Harm Results in Harm to CHDC Residents.

319. Expert Osgood has approximately 20 years of experience and extensive knowledge regarding systems for protecting individuals with developmental disabilities from harm. Osgood Tr. 37:3-17, 278:11-24. Ms. Osgood's experience includes developing and implementing protection from harm systems, evaluating between 25 and 30 protection from harm systems in at least 15 states, and drafting policies and providing technical assistance for state agencies that

provide services to individuals with developmental disabilities. Osgood Tr. 38:13-40:12; US Ex. 1-1.

320. Expert Carla Jo Osgood concluded that CHDC's protection from harm practices substantially depart from generally accepted minimum professional standards. She based this conclusion on interviews with CHDC administrative and direct care staff and residents; review of thousands of pages of facility documents, including all investigations for an 18-month period, incident and injury reports, administrative reviews of resident injuries, restraint reports, clinical records, and meeting minutes for committees charged with review of resident harm and quality assurance practices; observation of daily incident review meetings in all facility areas; and observation of individuals throughout CHDC for approximately 10 days. Osgood Tr. 51:21-54:14. Because facilities must provide reasonably safe conditions for residents with a wide range of needs, Ms. Osgood also reviewed CHDC's identification of, response to, and preventive action regarding a sample of individuals who had significant and/or recurring injuries, physical assistance needs, or behavioral needs. Osgood Tr. 55:4-19.

B. CHDC's Substantial Departure from Generally Accepted Professional Standards of Protection from Harm in Incident and Quality Management Causes Repeated Harm and Risk of Harm to Residents.

321. Generally accepted professional standards require facilities to identify residents' risks of harm and take action to prevent such risks, both individually and systemically. Facilities do so by developing and monitoring adequate risk management plans, which incorporate the results of a root cause analysis of any incidents of harm, including the circumstances of how incidents occurred and how they can be prevented in the future. Osgood Tr. 97:9-98:22, 113:19-115:7, 184:16-186:5.

322. CHDC's reporting systems and incident management systems substantially depart from these generally accepted professional standards. CHDC's incident reporting systems are fragmented, and its incident management systems fail to include a root cause analysis to identify and respond to repeated types of injuries and repeated injuries to individuals. Osgood Tr. 101:14-104:25, 105:1-25, 112:13-113:18, 184:16-186:5, 298:1-15; Walsh Tr. 6020:24-6021:8; Miller Tr. 5035:8-5036:16; US Exs. 18, 19, 23-1, 23-2, 24 through 36. Without accurate, consistently reported data, CHDC cannot begin to address the root causes of incidents and take action to try to prevent future similar incidents.[1] Osgood Tr. 113:19-114:14.

323. CHDC's quality management practices substantially depart from generally accepted professional standards because they inappropriately focus on staff and facility-based concerns unrelated to resident rights and protection, such as compliance issues related to maintaining federal funding. Osgood Tr. 46:7-47:11, 116:14-122:15, 184:16-186:5; Miller Tr. 5023:21-5024:11.

324. CHDC's quality management practices fail to measure resident outcomes in a number of important areas, such as restraints, abuse and neglect and other serious incidents, resident rights restrictions, and ADA-required community integration. Osgood Tr. 118:25-122:15; Miller Tr. 5027:2-25, 5028:24-5029:1.

325. CHDC purports to address resident injuries through its incident review committees. The Central Incident Review Committee meeting minutes reveal, however, that a substantial proportion of meetings center on discussions of staff injuries, rather than resident injuries. Miller Tr. 5037:9-23. Central Incident Review Committee meeting minutes reflect qualitative

[1] Defendants' consultant's review of incidents also illustrates how CHDC's various data sources yield different data for the same types of incidents, such as for choking. Walsh Tr. 6118:14-6119:20 (showing that one data source reported 1 choking incident and another data source reported between 11 and 24).

discussions of individual staff injuries only, not individual resident injuries. Miller Tr. 5037:24-5038:21. Individual team incident review committee meeting minutes rarely note follow-up action to be taken in response to resident injuries. Miller Tr. 5040:5-9; US Ex. 37.

326. CHDC incident review committees discuss incidents summarily without addressing either the root cause of the incident or how to prevent future incidents. [2] Osgood Tr. 115:8-116:10; US Ex. 37. Accordingly, CHDC does not meaningfully respond to incidents to stop recurring harm to CHDC residents. Osgood 114:15-115:7; US Exs. 18, 19, 23-1, 23-2, 24 through 36 (and subparts), 68-1, 68-2, 68-3, 79, 366, 367, 368, 369, 370, 371, 373, 374, 375, 377, 378, 379, 380, 381, 382, 383, 462, 564-2, 564-8, 564-12, 564-14, 577-9.

327. Continued institutionalization of CHDC residents exacerbates harm caused by "institutional behaviors," which result when residents observe and model the other maladaptive behaviors that occur around them. Matson Tr. 1178:3-1179:18. A crowded institutional environment such as CHDC exacerbates violent and maladaptive behaviors, resulting in ongoing harm to CHDC residents. Richardson Tr. 602:16-22; Price Tr. 1682:6-15. Compounding this problem, CHDC staff do not promptly re-evaluate and update the behavioral plans of individuals for whom plans have been shown ineffective. Matson Tr. 1084:12-1085:25; Manikam Tr. 3142:8-3145:3 (detailing how delays result in non-alignment of assessments and treatment); *see, e.g.*, US Exs. 564-1, 564-26, 567-1, 578-31, 580-1, 701-1 through 701-6.

328. As a result of systemic deficiencies, CHDC residents suffer ongoing, repeated harm and repeated risk of harm. CHDC's own documents show that CHDC has failed and continues to fail

[2] Incident review committee meetings include only cursory reviews of incidents, as incident review committees typically run through an average of 20 to 30 incidents per hour meeting, spending only 1.5 to 3 minutes discussing each incident. Clendenin Tr. 1571:21-1574:9; *see also* Murphy Tr. 460:2-8 (incident review committee meetings typically last roughly 45 minutes).

to protect residents from repeated harm caused by: staff abuse/neglect (US Exs. 44, 45, 46, 48 through 52, 54 through 59, 61); staff failure to implement appropriate behavior plans to address injuries from other residents (US Exs. 24, 24-1 through 24-39, 25, 25-1 through 25-125, 26, 26-1 through 26-52, 27, 27-1 through 27-55, 28, 28-1 through 28-31, 29, 29-1 through 29-19, 32, 32-1 through 32-16, 35, 35-1 through 35-35, 36, 36-1 through 36-19); dangerous exposure to bloodborne pathogens from other residents (US Exs. 23-1, 23-2, 24, 24-1 through 24-39, 26, 26-1 through 26-52, 27, 27-1 through 27-55, 28, 28-1 through 28-31, 29, 29-1 through 29-19, 35, 35-1 through 35-35, 36, 36-1 through 36-19); staff failure to address preventable self-harm (US Exs. 29, 29-1 through 29-19, 30, 30-1 through 30-29); staff's inappropriate and excessive use of restraints (US Exs. 27, 27-1 through 27-55, 29, 29-1 through 29-19, 39-1 through 39-8, 49, 2010, 2016); and serious injuries such as fractures and lacerations from falls and other events that can be prevented by adequate supervision and appropriate risk and incident management procedures. US Exs. 24, 24-1 through 24-39, 25, 25-1 through 25-125, 26, 26-1 through 26-52, 29, 29-1 through 29-19.[3]

329. For example, CHDC documents reveal that resident ME lived at CHDC for 42 years before dying there at age 48 from respiratory failure due to aspiration pneumonia. *See* Price Tr. 6883:21-6884:5. CHDC's own documents show that ME suffered numerous injuries, assaults, and staff neglect over a representative 2-year time period of June 2007 to August 2009. CHDC failed to intervene with adequate treatment and behavior plan implementation for residents who repeatedly hit, bit, pushed, and scratched ME at least 20 times. CHDC did not adequately

[3] At trial, in response to Defendants' objection to the United States' summary Exhibits 24 through 36, the Court determined that the United States could use these summary exhibits in these post-trial filings, so that Defendants could have additional time to review the summaries and compare them to the underlying documents (the subparts of United States Exhibits 24 through 36), which the Court admitted at trial. Osgood Tr. 190:8-197:3.

supervise ME, and eventually discovered him engaged in dangerous activities on at least ten occasions, including one time with his feeding tube removed and seven times ingesting non-nutritive items such as feces, paper, and a book. CHDC's substandard supervision was particularly dangerous for ME because of his medical orders not to receive anything by mouth because he could aspirate and develop pneumonia (his cause of his death). As indicated by CHDC neurological checks and other injury documentation, ME also suffered numerous injuries from known and unknown causes, including two bruises in his genital area and at least a dozen known or suspected head injuries from falls or other incidents, including at least two that resulted in head lacerations. US Exs. 24, 24-1 through 24-39, 553-1.

330. Resident TN has resided at CHDC for more than 20 years, since he was a teenager. Resident TN has been the victim of at least seven substantiated maltreatment investigations, including incidents of physical and verbal abuse by staff and four incidents involving inadequate staff supervision. CHDC documents show that, over the same representative 2-year period, CHDC resident TN suffered at least 80 known or suspected head injuries. These reported head injuries may not represent all his injuries, as staff have failed to supervise TN at various times despite his being designated for enhanced supervision. At different times, staff have found him buckled naked into a recliner with bruises to his genital area and trunk and wandering alone on the grounds sidewalk when no one knew of his whereabouts while he was supposed to be under enhanced supervision. US Exs. 25, 25-1 through 25-125, 553-1.

331. Resident NM has been at CHDC for more than 40 years. Between July 2007 and July 2009, CHDC staff failed to intervene with appropriate treatment and behavioral interventions for residents who hit, scratched, and bit NM's face and body nearly 20 times. NM has been unnecessarily and repeatedly exposed to hepatitis B, a contagious bloodborne disease, by

CHDC's failure to address biting by a resident known by staff to have hepatitis B. Instead of taking action to prevent this ongoing harm, CHDC staff merely noted that the individual had a plan to address her biting, ignoring that the plan was obviously not working. NM also has suffered injuries, including possible head injuries, from falling at least 17 times. In September 2007, documenting 1 of the earliest falls during this 2-year period, CHDC staff noted that NM had recent falls that weekend and needed hands-on assistance at all times while walking. Nevertheless, NM fell at least 16 times after that acknowledgement of her needs and risk of injury. US Exs. 26, 26-1 through 26-52, 533-1.

332. Resident SM was admitted to CHDC at age 6 and has been there for more than 30 years. CHDC documentation shows that, between June 2007 and October 2009, CHDC staff failed to intervene with appropriate treatment and behavioral interventions for 2 residents who bit, hit, or scratched SM at least 18 times. CHDC continuously noted that "staff followed [the resident's] program and will continue to do so," but failed to take any action to revise the clearly ineffective plan. US Exs. 32, 32-1 through 32-16, 533-1.

333. CHDC also has subjected children to repeated harm that CHDC has failed to address and prevent. For example, youth ZS has been stomped on while restrained on a papoose board (causing a footprint-shaped abrasion on his face) and has suffered bruising and scrapes from staff strapping ZS onto a papoose board, contrary to Defendants' claim that individuals have not been injured in restraints. US Exs. 27, 27-1 through 27-55. According to CHDC documentation, from October 2007 until May 2009, CHDC staff failed to intervene with appropriate treatment and behavioral interventions for youth who bit, hit, scratched, pushed, or pinched youth ZS no less than 35 times. Instead of addressing these repeated harms, staff merely noted that those

individuals had behavior plans and staff would continue to follow them, despite that these plans clearly were not working. US Exs. 27, 27-1 through 27-55.

334. CHDC has also allowed another CHDC youth, RD, to suffer repeated injuries from other CHDC residents. CHDC staff took no action to rectify the repeated harm to RD, other than to continue to follow those individuals' ineffective behavior plans. Similar to youth ZS, CHDC allowed other residents to bite, push, or hit youth RD at least 20 times, per CHDC documentation, from June 2007 to August 2009. Youth RD also has suffered possible head injuries at least eight times, including two separate head lacerations requiring staples to close the wounds, as indicated by CHDC neurological checks and other CHDC documentation. US Exs. 28, 28-1 through 28-31.

335. Similarly, CHDC staff failed to intervene with appropriate treatment and behavioral interventions for other youth who kicked, slapped, hit, scratched, pinched, pushed or bit youth HB at least 20 times from June 2007 to April 2009, according to CHDC documentation. Again, CHDC staff merely noted that they were continuing to follow the individuals' ineffective behavior plans. CHDC's use of mechanical restraints has also injured youth HB. After staff put him in a mitten jacket, youth HB fell off a couch and, unable to break his fall, suffered a possible head injury and bruised eye. CHDC has failed to prevent other head injuries to HB. CHDC's inability to address HB's ongoing headbutting behavior has resulted in possible head injuries at least a dozen times. US Exs. 29, 29-1 through 29-19.

336. CHDC has similarly failed to intervene to implement appropriate resident behavior plans to prevent repeated injuries to youth DK, as indicated by CHDC documentation from June 2007 to September 2009. CHDC's failure to implement appropriate behavioral interventions resulted in other youths biting, hitting, slapping, kicking, or scratching DK at least 40 times. DK suffered

possible head injuries from CHDC's repeated failures to intervene. Again, CHDC's only apparent response to the continued injuries to DK by the same individuals was to keep following those individuals' ineffective behavior plans. US Exs. 35, 35-1 through 35-35.

337. Similarly, CHDC documentation shows CHDC has failed to implement appropriate behavioral interventions to address injuries caused by residents repeatedly biting or hitting CHDC youth DG at least 20 times between August 2007 and March 2009. CHDC merely continued to note that the residents who repeatedly harmed DG had behavioral "strategies" (not even a full behavior plan), which staff would continue to follow, despite that these "strategies" clearly were failing. US Exs. 36, 36-1 through 36-19.

338. CHDC uses mechanical restraints improperly in lieu of adequate assessment and behavioral treatment. Manikam Tr. 3162:21-3163:3. For example, CHDC staff have not developed or implemented appropriate behavioral interventions to address individuals' repeated self-injurious behaviors ("SIB"). Instead, staff have caused more injuries to these individuals by using mechanical restraints instead of effective preventive measures to address individuals' repeated SIBs. CHDC documentation shows that, from August 2007 to July 2009, CHDC youth TC suffered bruised and swollen eyes and numerous bruises and abrasions to his body from SIB. CHDC's use of mechanical restraints to address TC's behaviors have caused additional injuries to TC - such as bruises, cuts, and scrapes - and have not addressed the underlying causes of, or prevented, TC's ongoing SIB. US Exs. 29, 29-1 through 29-19.

339. Similarly, pursuant to CHDC documentation from June 2007 to March 2009, CHDC resident DC has repeatedly slapped and hit himself in the face, resulting in possible head injuries more than 10 times. Instead of developing a plan to address the underlying causes of this

behavior, CHDC responded inappropriately by strapping him on a papoose board, causing DC additional harm. US Exs. 30, 30-1 through 30-44.

340. Compounding the ongoing harm and risk of harm from repeated injuries, CHDC fails to investigate possible sexual abuse, even when a resident suffers suspicious injuries. For example, bruising to a resident's genital area did not prompt CHDC to investigate whether physical or sexual abuse caused the injury, even though the resident resides on a unit that houses residents with histories of aggression and sexually inappropriate behaviors. R. Brewer Tr. 6750:22-25, 6752:1-22. CHDC also failed to investigate other suspicious injuries for possible sexual abuse, including a scratch to a resident's buttock, a bruise to a resident's inner thigh, and a bite mark on another resident's inner thigh. Miller Tr. 5029:18-5030:2. For the resident whose inner thigh was bitten, CHDC concluded the injury investigation by simply stating that the resident tended to untruthfully blame others. Miller Tr. 5030:3-8.

341. CHDC has not conducted any sexual abuse investigations in the last five years and has never conducted a sexual abuse investigation regarding a non-verbal resident, according to long-time CHDC employee and quality assurance director Gail Miller. G. Miller Tr. 5029:14-21.

C. CHDC's Substantial Departure from Generally Accepted Professional Standards of Protection from Harm Regarding Abuse and Neglect by Staff Results in Injury and Risk of Injury to CHDC's Residents.

342. CHDC fails to take systemic action to address, or attempt to prevent the recurrence of, staff's ongoing and pervasive abuse and neglect of children and adults, sometimes at the hands of repeat staff offenders. Osgood Tr. 153:18-156:18, 171:24-172:4, 184:16-186:5, 295:16-297:1; US Exs. 43 through 63.

343. Defendants' own consultant, Dr. Kevin Walsh, found that CHDC's abuse and neglect rate of .054 per person per year greatly exceeded the rates of comparable facilities. Walsh Tr. 6121:11-6122:11.

344. CHDC ineffectively addresses repeated CHDC staff abuse and neglect by merely terminating the individual staff found culpable for resident abuse and neglect, without conducting an analysis of frequent alleged perpetrators, frequent resident victims, types of incidents, where incidents are occurring, who reports incidents, and the shifts during which abuse occurs. Osgood Tr. 174:13-175:3. Instead of this analysis required by generally accepted professional standards, CHDC relies on administrative reviews and incident reviews that document incidents, but do nothing to determine the root cause of incidents and prevent future incidents. Osgood Tr. 152:12-21 (incident review committee and administrative review each indicate that the other will review the incident, resulting in follow-up action being taken by neither); Weaver Tr. 311:9-326:2 (illustrating such cyclical paper processes as to resident ME), 326:13-328:24 (illustrating cyclical paper processes as to resident ZS); Murphy Tr. 437:23-442:3 (illustrating cyclical paper processes as to resident HB), 442:25-448:25 (illustrating cyclical paper processes as to resident BB), 448:12-450:12 (illustrating cyclical paper processes as to resident CA); *see also* Osgood 174:13-175:3 (CHDC terminating individual staff is insufficient to address repeated abuse and neglect).

345. CHDC staff's ongoing serious acts of abuse and neglect have caused serious harm, and risk of harm, to CHDC adults and children. Osgood Tr. 50:19-51:20; US Exs. 43 through 63, 27-13, 52. On multiple occasions, CHDC staff continued to work with CHDC residents even though they had abused or neglected CHDC residents, or had previously been investigated for abuse or neglect. US Exs. 45 (staff previously accused of physical abuse of resident and

continued to provide direct care to CHDC residents), 47 (staff disciplined on 4 prior occasions and continued to work with CHDC residents), 48 (staff repeatedly disciplined, accused of physical and verbal abuse of resident, and continued to work with CHDC residents), 50 (staff terminated in 2005 for physical abuse of CHDC resident but subsequently returned to duty).

346. As to children, CHDC staff have forced a resident to assault another child while staff restrained the child victim, causing bruises to the child's hands, forearms, legs, back, and chest. Osgood Tr. 158:1-6, 159:3-19; US Ex. 43. Staff have severely beaten several CHDC youth. One staff was fired, later reinstated, and then found to have banged one youth's head against a door, causing a swelled bloody nose. Osgood Tr. 159:24-162:9; US Ex. 44. Another staff sat on and choked a youth resident, causing serious harm and serious risk of harm from asphyxiation. Osgood Tr. 162:10-25; US Ex. 45. This staff previously had been investigated for grabbing a resident by the neck and forcibly sitting him down, but the investigation was not substantiated and the staff member returned to work. Osgood Tr. 162:10-25; US Ex. 45. A different staff person scratched a child, twisted his arm, and tried to force the child to go to another residence. Osgood Tr. 163:5-15; US Ex. 46.

347. Staff gave another youth footprint-shaped purple abrasions across his face, after the staff immobilized him in a papoose board and stomped on the youth's face. Osgood Tr. 163:18-166:19; US Exs. 27-13, 47, 48. The youth had previously reported that the same staff member hit him and called him names every day. Osgood Tr. 164:1-13. This staff member had two prior abuse allegations – one for grabbing a resident by the collar, dragging him outside, and forcing him into a chair (US Ex. 55), and another for grabbing a resident by the neck, putting him in a headlock, and lifting and dragging the resident (US Ex. 62). Osgood Tr. 165:6-13, 167:16-168:23. This staff member had received multiple forms of discipline for other on-the-job

conduct as well. Osgood Tr. 164:14-165:6. Even after the staff member stomped on the youth strapped on a papoose board, the youth's safety plan still permitted staff to restrain him in a papoose board, despite that generally accepted professional standards require evaluation of the possible effects of restraint use for individuals who have been abused while restrained. Osgood Tr. 166:20-167:15. CHDC did not even ensure that this youth's program coordinator became aware of this significant incident when she received the youth on her caseload. Weaver Tr. 339:1-22.

348. CHDC staff also have abused and injured adult residents. One CHDC resident was beaten repeatedly with a broken coat hanger and suffered numerous whelps across her back, arms, shoulders, chest, and buttocks. Osgood Tr. 170:5-171:11; US Ex. 50. The staff member who severely abused this CHDC resident previously had been terminated for abuse but was permitted to return to work after she was able to pass a polygraph test. Osgood Tr. 171:12-23.

349. Another CHDC staff member abused a resident using a belt buckle as a weapon. Osgood Tr. 172:13-23; US Ex. 2015. The staff's abuse was revealed when the resident was discovered to have a bruise matching the shape of a staff member's belt buckle. Osgood Tr. 172:13-23; US Ex. 2015. This resident had been the victim of staff abuse or neglect on multiple prior occasions as well, including at least two substantiated instances of physical abuse and at least three substantiated incidents of neglect, one of which involved staff members who strapped the resident naked into a recliner and left him unattended, chewing on a blanket. Osgood Tr. 172:24-174:12.

350. Other incidents in which CHDC residents have suffered physical abuse include an instance where a staff person hit a resident in the chest with a keyboard, and told another employee, "you did not see this." Osgood Tr. 175:8-5; US Ex. 51. Another CHDC staff member

punched a resident who was in a wheelchair. Osgood Tr. 176:24-177:14; US Ex. 54. Another staff member became involved in an altercation with a CHDC resident and struck the resident repeatedly in the head. Osgood Tr. 178:24-180:5; US Ex. 57. Other staff members: hit a CHDC resident as the staff took a jacket away from him (Osgood Tr. 176:9-21; US Ex. 52); hit a CHDC resident in the face with a magazine (Osgood Tr. 177:17-178:4; US Ex. 56); pushed a resident down onto the floor in a living unit day room (Osgood Tr. 181:9-25; US Ex. 59); stepped on a resident's hand when the resident was agitated (Osgood Tr. 183:2-22; US Ex. 61); and grabbed a resident by the neck and shoved her into her room, taking the resident's blanket away "to make her behave." Osgood Tr. 180:9-181:5; US Ex. 58.

351. In addition, CHDC staff have verbally abused or threatened CHDC adult and children residents. Osgood Tr. 178:7-20; US Ex. 53 (CHDC staff threatening to hit CHDC resident if he had hit another resident and cursing at the same resident after he soiled himself); Osgood Tr. 182:4-17; US Ex. 60 (CHDC investigation confirming discourteous conduct for staff member who verbally abused CHDC resident).

352. CHDC also perpetuates an environment in which staff do not feel safe reporting alleged abuse and neglect. Discouraging staff from reporting alleged acts of abuse or neglect, CHDC disciplines and even terminates staff who report late, even if the delay in reporting is due to intimidation by the alleged perpetrator of the abuse. Osgood Tr. 156:19-157:18. In addition, a large portion of staff who report abuse and neglect are recently hired, indicating that CHDC fosters a culture of silence into which staff are eventually inducted. Osgood Tr. 156:19-157:18, 158:1-21, 168:10-18; US Ex. 43 (abuse reporting staff did not report immediately because he did not trust the shift coordinator's relationship with the alleged perpetrator, yet was terminated for late reporting); Osgood Tr. 181:8-23; US Ex. 59 (reporting staff had one month on the job); US

Ex. 60 (reporting employee had three months on the job); Osgood Tr. 183:1-19; US Ex. 61 (reporting staff had two months on the job); Osgood Tr. 168:10-23; US Ex. 62 (alleged perpetrator not disciplined for unsubstantiated allegations but reporting staff member received a written warning for late reporting). Consequently, staff likely do not consistently report alleged acts of abuse or neglect, and CHDC's failure to investigate and address alleged acts of abuse and neglect of CHDC residents continues to expose residents to harm.

D. CHDC's Substantial Departure from Generally Accepted Professional Standards of Restraint Use Results in the Excessive and Inappropriate Use of Restraints and Violates the Rights of Residents.

353. CHDC uses outdated and highly restrictive forms of mechanical restraints on both adults and children. These mechanical restraints include papoose boards, which other states have not used for a number of years, and restraint chairs, which most facilities have eliminated in the last ten years. Osgood Tr. 47:12-48:7, 145:2-147:2, 277:20-278:4, 293:2-294:15. Other states have banned or are considering banning the use of all mechanical restraints on children. Osgood Tr. 276:4-12.

354. Generally accepted professional standards require restraint reviews, which include an inquiry into: the precipitating factors that led to the restraint (including any de-escalation that was conducted before the restraint), how the restraint was employed, whether the restraint was applied in accordance with policy, whether the individual was monitored during the restraint to prevent injury, whether there are any significant restraint trends, and what actions can be taken to prevent future restraints. Osgood Tr. 48:19-49:11, 130:19-131:9.

355. CHDC fails to ensure that staff restrain residents only in emergency situations necessary to prevent harm to the resident or others and only for the length of time necessary for the emergency to subside. CHDC also does not conduct a documented review of each restraint to

examine these factors or to take steps to prevent future incidents of inappropriate restraints. Osgood Tr. 48:8-49:11, 127:14-130:6, 184:16-186:5; Miller Tr. 5027:6-12; US Ex. 39-1 through 39-8. Moreover, CHDC's restraint data is underinclusive because CHDC does not record the use of restrictive garments as restraints. Osgood Tr. 130:7-18.

356. As a result, CHDC's restraint use substantially departs from generally accepted standards requiring that staff use restraints only in emergency situations necessary to prevent harm to the resident or others and only for the length of time necessary for the emergency to subside. Osgood Tr. 48:8-49:11.

357. For example, staff have improperly restrained or threatened to restrain CHDC residents for punitive reasons. In one incident, CHDC staff retaliated against a resident by pinning down the resident, telling her that she was "going to the board," and then restraining her on a papoose board. Osgood Tr. 134:18-136:10; US Ex. 2016. Another time, a CHDC staff put a resident in a chokehold, dragged her across the floor, physically restrained her, and then strapped her on a papoose board, in retaliation for the resident biting the staff. Although the staff abuse was investigated, CHDC did not investigate the improper use of restraint. Osgood Tr. 142:24-144:13; US Ex. 49. In yet another incident, a nurse yelled at a resident that if the resident did not take her medication, the resident would be put on a papoose board. Osgood Tr. 136:14-25, 141:22-142:2; US Ex. 2010. A CHDC resident also told Ms. Osgood that, when the resident acted up, staff strapped her on the papoose board, which caused injuries to her wrists. Osgood Tr. 144:15-145:1.

358. CHDC residents are inappropriately restrained so often that they have been accustomed to it. A CHDC resident confirmed with one of Defendants' consultants that she is restrained for

punishment, but that it is "not a big deal" – a statement that even Defendants' consultant finds "troubling." Gale Tr. 5733:17-5734:4.

359. CHDC restraint plans reflect inappropriate criteria for release. *E.g.*, US Ex. 40 (safety plan indicating that CHDC resident should be "apologetic" before being released from restraints); Osgood Tr. 131:10-133:11 (safety plan requiring that individual be apologetic before being released from restraints demonstrates punitive restraint use); Gale Tr. 5734:20-24 (CHDC resident stated that she must agree not to engage in undesired behavior again before being released from restraints).

360. Because CHDC does not track injuries in restraints, CHDC is unaware that residents have suffered such restraint injuries, indicating that restraints may be harming more than protecting CHDC residents. Osgood Tr. 84:7-22, 148:9-153:15, 268:8-20 (CHDC resident placed on papoose board while x-rays of her hip were pending, risking further injury of the individual's hip); US Exs. 8 (injuries in restraints included abrasions and bruising), 27-13 (youth ZS stomped on in papoose board, suffering footprint-shaped abrasion to face), 39-1 (in response to discovery request, CHDC indicated there had been no injuries resulting from restraint use), 39-2 (resident received pain medication after being placed on papoose board), 39-3 (resident was put on papoose board and hurt his foot), 39-4 (blister from seat belt restraint), 39-5 (red marks from arm splint restraints), 39-6 (scratches from restraint), 39-7 (abrasion from papoose board strap), 39-8 (bruise to hip from papoose board).

E. CHDC's Substantial Departure from Generally Accepted Professional Standards of Protection from Harm in Staffing and Supervision Results in Harm to CHDC Residents.

361. CHDC has insufficient staff to adequately supervise residents, to provide adequate care and supports to its residents, and to protect residents from ongoing harm and risk of harm. Osgood Tr. 76:14-76:25, 283:14-284:12.

362. For example, CHDC staff's inadequate supervision caused the death of a CHDC resident, known to be at risk of choking because staff had observed her filling her mouth too full, eating fast, and swallowing without chewing on various occasions. US Ex. 6-3 at CON-US-0009499. CHDC staff were supposed to observe her during mealtime and redirect her to avoid these behaviors. Left unsupervised one evening, resident AR choked on bologna in a housing unit kitchen. Osgood Tr. 77:1-78:13; US Exs. 6-1, 6-2 & 6-3. Following AR's death, CHDC did not take corrective action – until the state agency that monitors CHDC, the Arkansas Office of Long-Term Care ("OLTC"), conducted an investigation. Osgood Tr. 78:2-7.

363. CHDC also has failed to protect residents who it knew were at risk of pica (ingesting non-nutritive items), as shown by incidents in which residents tore out catheters and feeding tubes, or ingested markers, crayons, books, cups, pieces of Attends, a deodorant spray nozzle, and feces. Osgood Tr. 79:3-81:4, 83:8-24, 89:23-90:18, 91:16-24, 92:5-93:4; US Exs. 7-1, 7-2, 7-3, 8, 13, 15, 16.

364. CHDC also places residents at risk of serious harm by not following through on orders for increased supervision. For example, CHDC staff has left individuals on suicide watch unattended and individuals assigned visual supervision unattended in a parking lot. Another resident suffered injuries after CHDC staff left the resident unattended and the resident jumped off a desk. Osgood Tr. 85:4-89:16, 90:25-91:10; US Exs. 9, 10, 11, 12-1, 12-2, 14. As the

examples illustrate, CHDC's staffing and supervision substantially departs from generally accepted professional standards and places CHDC residents at continued risk of harm.

365. On-site observations also revealed inadequate staff supervision. Ms. Osgood observed several residents at risk of harm from inadequate supervision during her site visits at CHDC. Osgood Tr. 94:16-97:8. For example, one man had wrapped a plastic apparatus around his neck (characterized by CHDC as "chewelry"), another woman whose one eye had been enucleated was seen poking at her remaining eye, and another woman had a bleeding laceration that CHDC staff appeared not to have detected. Osgood Tr. 95:13-96:5. Other individuals were sitting idly, not apparently engaged in any activities or active treatment. This is significant because lack of meaningful activity is associated with increased resident injuries. Osgood Tr. 95:2-12, 96:15-97:7.

366. CHDC's superintendent Price conceded that direct care staffing is a primary issue for CHDC. Mr. Price recalled times that CHDC has had to count secretaries or teachers as direct care staff in order to meet minimum CMS staffing ratio requirements. Price Tr. 1686:7-25. When the United States' experts were on-site, CHDC artificially improved staffing ratios by refusing to approve any staff leave during those days. Price Tr. 1686:16-22.

F. CHDC's Substantial Departure from Generally Accepted Professional Standards of Protection from Harm in Staff Training Results in Harm to CHDC Residents.

367. CHDC has inadequate systems and procedures to protect clients and staff from harm. CHDC's deficiencies include an absence of comprehensive policies and procedures and insufficient competency-based training to guide staff in providing adequate care and supervision to residents. Osgood Tr. 45:15-46:4, 57:25-58:15, 184:16-186:5. As a result, staff are not

familiar with the supports and services that residents in their care need. This harms individuals and places them at risk of harm. Osgood Tr. 45:15-46:4, 57:25-58:15, 184:16-186:5.

368. Ms. Osgood found that CHDC's systemic deficiencies resulted in harm and risk of harm to residents. Defendants' consultant, Dr. Kevin Walsh, conducted no analysis of whether harmful outcomes to CHDC residents showed systemic deficiencies. Walsh Tr. 6118:2-13. Nor did Dr. Walsh evaluate a single individual to see whether any individual suffered repeated injuries or whether individual rates of injuries improved over time. Walsh Tr. 6127:15-18.

369. As recently as Summer 2010, CMS found that CHDC placed individuals in immediate jeopardy. Specifically, CMS found that CHDC violated the "client protection" condition of participation, an extremely rare and serious adverse finding.[4] Osgood Tr. 65:20-68:14, 280:9-19; US Ex. 4. This finding was precipitated by an incident in which CHDC staff left a resident unattended in a locked wheelchair in extreme heat for nearly four hours, soiled and suffering from heat stroke. Osgood Tr. 69:1-70:5; US Ex. 4. The CMS survey, conducted by State OLTC staff, also revealed that CHDC was not timely completing investigative reports in accordance with CMS regulations. Osgood Tr. 70:6-70:15.

370. CHDC's inadequate systems and procedures also led to the sexual assault of a CHDC resident. CHDC staff permitted a non-CHDC resident to stay overnight, unsupervised, with the CHDC resident. During this visit, the individual sexually assaulted the CHDC resident. Osgood Tr. 58:16-61:5; US Ex. 2. CHDC had no policy or procedure to instruct staff how to supervise residents during overnight visits, including how to make room assignments or whether and how to conduct bed checks. Osgood Tr. 59:13-19. In addition, this CHDC resident has a hearing impairment and needed to report the sexual assault to a peer because there apparently was no

[4] *See* 42 C.F.R. § 4893.

staff versant in sign language to receive his report of sexual abuse. Osgood Tr. 59:18-24. Even after this incident, CHDC failed to implement comprehensive procedures for overnight trips. Osgood Tr. 60:6-17.

371. CHDC's inadequate systems and procedures also caused CHDC staff to leave a non-verbal child with autism and seizure disorder alone in a housing unit overnight with no supervision. Osgood Tr. 61:16-63:20; US Ex. 3. If this child had suffered a seizure overnight, he would have had no one to help him. CHDC staff left the child after moving all other residents out of a housing unit due to a staffing shortage. Although this was not the only instance in which CHDC staff had to move all individuals out of a housing unit due to a staffing shortage, CHDC still had no procedural guidelines for moving individuals out of their residence overnight. Osgood Tr. 62:20-63:20. Such procedural guidelines should include how to ensure that all individuals are transported to the correct location and what documentation must accompany the individuals. Osgood Tr. 63:2-63:20. Even after creating a protocol following this incident, CHDC failed to adequately train staff on procedures for overnight moves: Ms. Osgood interviewed a number of staff, and they were unable to articulate the protocol. Osgood Tr. 63:25-64:16.

372. CHDC staff training substantially departs from generally accepted professional standards because it is not sufficiently competency-based, *i.e.*, it does not measure whether staff understand what they are supposed to perform and how they are supposed to perform it. Osgood Tr. 71:14-73:16. As a result, staff do not have the tools they need to provide adequate care and supervision to individual residents and are not familiar with the supports and services that residents in their care need. Osgood Tr. 49:12-50:18.

373. In particular, CHDC relies on "quick reference guides" ("QRGs") as a replacement for adequate staff education. This is especially problematic for "float staff," who often are assigned to the most high-risk individuals at CHDC without familiarity or training regarding the needs of individuals in their care. Osgood Tr. 49:23-50:18, 73:20-75:4. For example, a CHDC resident was injured from a fall after staff relied on a QRG that did not disclose protective equipment required for the resident. Osgood Tr. 75:5-76:2; US Ex. 5. In other investigations as well, CHDC's reliance on QRGs resulted in harm to individuals because staff were found not to have read those guides. Osgood Tr. 76:3-8.

374. CHDC also relies on a "read and sign" method of training staff on new or revised policies and procedures. *See* Price Tr. 6895:12-18. This substandard method fails to ensure that staff gain the competencies needed to implement the policies and procedures. Osgood Tr. 64:17-65:4.

G. CHDC Fails To Protect Resident Rights Adequately.

375. CHDC does not ensure protection of resident rights. CHDC's resident rights practices fail to address certain types of rights restrictions, including the placement of cameras in resident housing units. Specifically, CHDC placed cameras in housing units without obtaining prior consent from the facility human rights committee, individuals, or their parents/guardians. Osgood Tr. 123:9-124:16; Price Tr. 6906:5-13. Only later did CHDC inform parents and guardians of the cameras. Osgood Tr. 124:5-16.

376. CHDC fails to ensure that consent for treatment and services is informed and voluntary. Instead, CHDC relies on an informed consent policy that permits CHDC to discharge residents if they or their parent or guardian will not consent to any proposed restriction of resident rights that requires informed written consent, *i.e.*, administration of psychotropic medications. Osgood Tr. 124:17-127:11; US Ex. 38.

V. CONCLUSIONS OF LAW – PROTECTION FROM HARM

Defendants systematic violation of CHDC residents' constitutional right to protection from harm causes harm to residents from staff abuse and neglect, inappropriate and excessive use of restraints, and repeated serious injuries such as lacerations, fractures, and harm from other individuals. The Fourteenth Amendment requires that CHDC provide residents reasonably safe conditions of confinement and protection from unreasonable risks of harm. *See Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982) (requiring states to take the necessary steps to ensure that facilities provide residents reasonably safe conditions of confinement and reasonable protection from harm); *Andrews v. Neer*, 253 F.3d 1052, 1062 n.8 (8th Cir. 2001) (noting that *Youngberg* and its Eighth Circuit progeny require "vulnerable patients [ ] to be protected, through before-the-fact measures, from themselves, other patients, or the deliberate harmful actions of the institution's staff members"); *see also Helling v. McKinney*, 509 U.S. 25, 34-35 (1993) (affirming that the Eighth Amendment requires protection from unreasonable risk of future harm). In violation of this constitutional requirement, Defendants harm residents with a protection from harm system that substantially departs from generally accepted minimal professional standards.

CHDC's substandard systems and procedures to protect residents from harm, including policies and procedures to guide staff in providing care and supervision to residents and adequate competency-based staff training,[5] fail to provide CHDC residents with constitutionally reasonably safe conditions. *Youngberg*, 457 U.S. at 315-16. CHDC violates residents' constitutional right to reasonably safe conditions by failing to provide sufficient staff to

[5] Federal Medicaid regulations, and particularly 42 C.F.R. § 483.430(e), require that staff training be competency-based. *See* 42 C.F.R. § 483.430(e) ("Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.").

adequately supervise residents, to provide adequate care and supports to its residents, and to protect residents from ongoing harm and risk of harm. *Id.*

CHDC also violates residents' constitutional right to reasonably safe conditions by failing to prevent risk of serious harm through development and monitoring of adequate risk management plans and by failing to identify and respond to repeated types of injuries and repeated injuries to individuals. *Youngberg*, 457 U.S. at 315-16; *Helling*, 509 U.S. at 34-35. Rather than focusing on improving the health and safety of residents, CHDC's quality management practices inappropriately target the facility's efforts to try to maintain compliance with federal funding and other regulations, as well as other facility-based concerns (such as employee worker's compensation issues). Failing to take action to avoid harm and ongoing risk of harm to residents following staff abuse and neglect, inappropriate and excessive use of restraints, and repeated serious injuries such as lacerations, fractures, harm from other individuals, and exposures to bloodborne pathogens, exhibits CHDC's lack of professional judgment and, as such, constitutes a substantial departure from minimum professional standards. *Youngberg*, 457 U.S. at 323.

CHDC violates residents' rights to reasonable safety by utilizing outdated and highly restrictive forms of mechanical restraints on both adults and children, and by failing to ensure that such restrictive physical and mechanical restraints of residents are applied only in emergency situations necessary to prevent harm to the resident or others and only for the length of time necessary for the emergency to subside. *Id.* at 316-18; *Society for Good Will to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239, 1245 (2d Cir. 1984) (holding that patients of mental health institutions have a right to freedom from undue bodily restraint); *Thomas S. v. Flaherty*, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988) ("It is a substantial departure from professional

standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior. Seclusion and restraint should only be used as a last resort."); *see also* 42 U.S.C. § 290ii(b) (specifically prohibiting restraining practices employed by CHDC, by requiring that restraints on ICF/MR residents only be used to ensure physical safety and only as ordered by a licensed practitioner who clearly specifies the duration and circumstances (except in certain emergency circumstances)). CHDC violates residents' rights by applying restraints for punitive reasons, applying restraints that exceed safety requirements, and by conditioning release from restraint on inappropriate factors, such as apologizing.

CHDC fails to provide reasonably safe conditions for CHDC residents by not taking systemic action to address or attempt to prevent recurrence of staff abuse and neglect of children and adults. *Youngberg*, 457 U.S. at 315-17. CHDC exacerbates the risk of ongoing serious harm by failing to ensure an environment in which staff feel safe in reporting alleged abuse and neglect, resulting in inconsistent investigations of alleged acts of abuse and neglect of CHDC children and adults.

Defendants' own documents provide further evidence of Defendants' substantial departure from professional standards in CHDC's protection from harm practices. These documents prove that CHDC is not even complying with regulations for facilities receiving federal Medicaid funding that require specific steps to be taken to protect residents from abuse and neglect. *See, e.g.*, 42 C.F.R. § 483.420(a)(5) ("[T]he facility must. . . [e]nsure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment"); 42 C.F.R. § 483.420(d)(1) ("The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client."); 42 C.F.R. § 483.420(d)(3) ("The facility

must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress."); 42 C.F.R. § 483.420(d)(4) ("The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.").

CHDC's resident rights practices also fail to address certain rights restrictions (such as cameras) and fail to ensure that consent by residents or residents' parents and guardians is informed and voluntary. *See* 42 C.F.R. § 483.10(a)(2) ("A facility must protect and promote the rights of each resident, including . . . the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.").

In sum, CHDC's many systemic failures and deficiencies in staff supervision and training, incident reporting, quality management practices, protection of resident rights, staff abuse and neglect, and use of mechanical restraints violate residents' constitutional rights to reasonably safe conditions of confinement and protection from unreasonable risks of harm, subjecting residents to repeated, preventable harm.

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VI. FINDINGS OF FACT – PSYCHOLOGY AND BEHAVIORAL SERVICES

377. CHDC's psychological and behavioral services substantially depart from professional standards, causing harm, and risk of harm, to CHDC residents. Instead of providing individualized psychological assessments and treatment, CHDC staff respond to residents' behaviors by restraining them at astronomical rates that vastly exceed norms in other states. *See generally* FOF Part VI.A-G.

378. CHDC staff fail to conduct appropriate assessments, though accurate and comprehensive assessments make up the building blocks of a treatment plan. Rather than employing widely recognized, scientifically validated instruments, CHDC staff utilize *ad hoc* procedures to evaluate resident cognition, adaptive function, and behavioral function. *See generally* FOF Part VI.D-E.

379. CHDC also fails to monitor and re-assess residents over time to ensure that treatment plans are individualized and respond to changes in residents' conditions and needs. Staff take months to prepare or modify treatment plans, even after agreeing that changes are necessary. While they await appropriate treatment, CHDC residents are restrained repeatedly. *See generally* FOF Part VI.B-D.

380. CHDC should use restraints only to address problem behaviors as a last resort when psychological treatment fails. In practice, however, CHDC does not provide the necessary psychological services that would promote safety and independence. Though Defendants fail to implement effective positive behavior interventions, Defendants maintain that the behaviors they fail to address justify continued segregation of CHDC residents. *See generally* FOF Part VI.A-G.

381. CHDC's most commonly used mechanical restraint devices are unusually restrictive. They include papoose boards, straitjackets, and restraints chairs. Other institutions across the

country rarely, if ever, use such devices even when restraints may be deemed necessary. Most problematically, CHDC staff regularly use even the most restrictive mechanical devices on young children, a group that generally is not even institutionalized, let alone subjected to papoose boards. *See generally* FOF Part VI.B. Moreover, CHDC uses a host of procedures – including electro-convulsive shock therapy, chemical restraints, seclusion, and one-to-one supervision – that CHDC does not systematically track. So, CHDC's use of restrictive methods is likely even higher than CHDC reports. *See generally* FOF Part VI.B.

382. Staffing and staffing training cause much of CHDC's substandard psychological services. Nearly all of CHDC's psychology staff are master's level practitioners who do not have the necessary education, training, or experience to provide the psychological services and habilitation necessary for CHDC residents. As a result, residents suffer harm from both unnecessary restraints and their unaddressed psychological behaviors. *See generally* FOF Part VI.E-F.

383. Several of the unlawful deficiencies identified by the United States in psychological services were also noted by the Arkansas Department of Education, in its report on special education services at CHDC. *Compare* US Exs. 1197-1198, 1201, 1203, 1211, 1214, 1216, 1217 (lack of: staff, behavioral interventions in the school setting, integration of services, and attention to communication issues), *with* Matson Tr. 1095:13-1097:25.

A. Experts Dr. Johnny Matson and Dr. Ramasamy Manikam Credibly Testified That CHDC's Psychological and Behavioral Services Substantially Depart from Generally Accepted Professional Standards, Causing Harm, and Risk of Harm, to CHDC Residents.

384. Dr. Johnny Matson is a licensed clinical psychologist. He has practiced for 34 years, and currently works as a professor, distinguished research master, and director of clinical training in the Department of Psychology, Louisiana State University. Over the course of his career, he has

consulted at 39 developmental centers in 18 states. He serves as editor for 2 professional journals and has published approximately 500 articles and 30 books. Matson Tr. 990:3-1001:9; US Ex. 551. Dr. Matson received the Frank J. Menolascino Award from the National Association for the Dually Diagnosed, and his peers have recognized him as one of the leading experts in the fields of developmental disabilities and behavior therapy. He testified as an expert on applied behavioral analysis and psychological treatment of people with developmental disabilities. Matson Tr. 990:3-1001:9; US Ex. 551. CHDC's chief psychologist, Dr. Carl Reddig, admits that Dr. Matson is an authority in the field of psychology. Reddig Tr. 1978:23-1979:5.

385. Dr. Ramasamy Manikam is a licensed clinical psychologist. His major areas of professional focus include autism, developmental disabilities, and self-injurious behavior. He has served as an associate editor for the Journal of Child and Family Studies. He provided expert testimony on applied behavioral analysis and psychological treatment of people with developmental disabilities. Manikam Tr. 3064:2-3068:22; US Ex. 584.

386. Drs. Matson and Manikam concluded that CHDC's psychological services substantially depart from generally accepted professional standards of care. *See generally* FOF Part VI.B-F. In forming his professional opinion, Dr. Matson completed 2 week-long tours of CHDC, during which he interviewed psychology staff, reviewed cases with staff, and examined a large volume of documents including resident behavioral plans and over 500 census summary data sheets. Matson Tr. 1001:10-1002:19. Dr. Manikam also completed two week-long tours of CHDC. While on-site, Dr. Manikam interviewed psychology staff and examined a large volume of documents, including treatment plans, restraint procedures, and psychology forms. Dr. Manikam also previously inspected CHDC in 2007, prior to this litigation. Manikam Tr. 3068:23-3075:8.

B. Instead of Providing Appropriate Psychological Care, CHDC Staff Restrain Residents with Excessively Harsh Methods, at Astronomical Rates, in Substantial Departure from Professional Standards.

387. Due to CHDC's failure to provide effective behavioral supports and services, CHDC routinely and needlessly subjects individuals to strikingly high rates of harmful restraints. CHDC does not provide timely and effective behavioral interventions that would help residents replace maladaptive behaviors with safe and appropriate ways of expressing themselves. *See* FOF Part VI.C-F. Lacking effective means to change residents' maladaptive behaviors, CHDC simply suppresses those behaviors through extraordinary rates and forms of harmful restraints. These include extensive use of various types of antiquated "mechanical" restraints (*i.e.*, restraint equipment), physical holds, and chemical restraints. CHDC employs these highly restrictive measures regardless of a resident's age and notwithstanding their obvious traumatic effect. *See* FOF Part VI.B. CHDC staff use even the most severe restraints on children, survivors of domestic violence, and in at least one case, on a child who abusive staff had previously deliberately stomped on after strapping the child to a papoose board. CHDC does not provide clinical oversight of its restraint use. In virtually no instance do CHDC psychology staff clinically assess the circumstances that led staff to restrain a resident or assess the impact that the restraint had on the individual or his/her behavior. Further, although CHDC's self-reported rates of restraint are high, CHDC's rates unquestionably undercount the actual rates of restraint it uses on residents. In summary, CHDC's harmful restraint practices substantially depart from generally accepted professional standards of care. *See* FOF Part VI.B.

388. CHDC restrains residents rather than addressing behaviors with adequate assessments and behavioral treatment. Manikam Tr. 3162:21-3163:3; *see* Matson Tr. 1178:4-1179:18; *see generally* Appx. For example, staff used restraints to address SA's aggression without intervening to address the suspected trigger for the aggression. Similarly, staff tied resident DB

to a papoose board instead of addressing environmental and communication factors triggering the behaviors. In yet another case, staff used papoose boards and physical holds on RC because the generic "point system" that Defense witnesses admit has not worked for other residents also did not work for RC. CHDC's other misuses of restraint include placing a resident in a jumpsuit for staff convenience, namely, to reduce the frequency with which staff had to redirect the resident from engaging in maladaptive behavior, and many more. *See* Appx. at 20, 21, 23, 28, 32 (Other specific examples include BH and LW.).

1) CHDC Routinely Uses Archaic Restraint Types That Substantially Depart from Professional Standards.

389. CHDC extensively uses 41 types of restraints, including antiquated restraint methods that do not comport with contemporary, generally accepted professional standards. Matson Tr. 1119:4-1120:18; Manikam Tr. 3157:5-3162:5; Reddig Tr. 1947:9-23; US Exs. 596 & 623. In particular, CHDC's widespread use of the papoose board, camisole jacket (a.k.a. straitjacket), and restraint chair, substantially departs from generally accepted contemporary practice. *See* Matson Tr. 1119:4-1120:22, 1255:7-10; Manikam Tr. 3157:5-3163:3. Notably, Defendants produced no evidence of any other jurisdiction that uses these outdated types of restraints on such a wide scale. *See also* Cooper Tr. 2425:21-2426:1 (never needed to create a restraint program at University of Arkansas Medical School), 2427:14-20; Warren Tr. 4721:1-4722:4 (no papoose board or CHDC-type restraint chair used in defense consultant's private practice facilities).

390. CHDC uses the outdated papoose board in behavior programs for approximately 18 percent of CHDC residents. Manikam Tr. 3157:5-3159:5.

391. The use of completely restrictive restraints, such as the papoose board, on children as young as the ones housed at CHDC, is unprecedented. Matson Tr. 1179:24-1180:1. Other

systems do not use such mechanical restraints at all on young children. *See* Matson Tr. 1119:16-1120:22, 1179:19-1180:10; Manikam Tr. 3160:16-3162:5 (states have gone restraint free and use of restraints on children is typically considered unnecessary), 3163:4-12 (other systems do not even admit children to residential facilities like CHDC). In contrast, CHDC uses severely restrictive procedures, including papoose boards, on a wide range on children. Examples include CA (18 years old, papoose board); SA (15 years old, papoose board and chemical restraints); DB (17 years old, papoose board); HB (13 years old, prone physical holds); RC (15 years old, papoose board and physical holds); TC (9 years old, helmet and papoose board); ZS (12 years old, papoose board), LW (10 years old, soft shell helmet used without appropriate safeguards and treatment plan). *See* Appx. at 12, 18, 20,21, 23, 24, 28.

392. CHDC's use of restraints in hazardous locations increases the risk of resident injury. *See, e.g.*, Matson Tr. 1180:5-10 (restraint chair located in difficult to supervise location at back of housing unit, with sharp objects in vicinity).

393. CHDC has used highly invasive techniques, such as electroconvulsive shock therapy ("ECT"), on at least one CHDC resident, BH, without showing that it first attempted appropriate behavioral interventions. Warren Tr. 4798:3-4799:12. CHDC's use of extreme measures without first attempting less drastic treatment is a substantial departure from generally accepted professional standards. *See generally* FOF Part VI.B-D; s*ee also* Manikam Tr. 3109:21-3010:24; US Exs. 30-12, 687. Similarly, CHDC staff considered pulling a resident's teeth to address the results of behavior (persistent rubbing of the gums) that CHDC should have assessed and treated with less drastic behavioral interventions. *See* Manikam Tr. 3109:21-3010:24; US Exs. 30-12, 687.

394. Defendants are also using inappropriate chemical restraints. Matson Tr. 1135:18-1136:23. CHDC staff use medications inappropriately to manage behaviors in lieu of appropriate diagnoses and behavioral programs. Matson Tr. 1135:18-1136:23. At CHDC, repeated mismatches between the actual behavioral symptoms being addressed and the purported diagnoses show that the psychiatrist uses medications to chemically restrain residents. Rather than targeting symptoms typically associated with the diagnoses CHDC staff cite when justifying the use of medications, they often target and taper treatment based on behaviors unrelated to the diagnoses, such as aggression, self-injury, or pica. If staff were actually treating the alleged diagnosis, their target and taper criteria would focus more on typical symptoms of such diagnoses. Matson Tr. 1135:18-1136:23.

395. Even if staff were not using inappropriate chemical restraints *per se*, CHDC's high rate of psychotropic medication use – at least 50% of the residents – indicates that CHDC's substandard behavioral interventions result "in overmedication and ineffective treatments." Matson Tr. 1240:8-16; Mikkelsen Tr. 3584:16-19.

2) CHDC's Frequency of Restraint Use Substantially Departs from Professional Standards.

396. CHDC uses mechanical restraints at the "astronomical" frequency of over 1,000 times per month. Matson Tr. 1126:10-18. In April 2009 alone, CHDC staff used "planned mechanical restraints," (*i.e.*, restraints implemented as part of a behavioral plan and not as unplanned, emergency restraints) 1,388 times. Manikam Tr. 3158:8-3158:13; *see, e.g.*, Appx. at 33, 36 (CHDC restrains individual residents, such as KH and NS, for extensive periods without adequate treatment.).

397. CHDC staff mechanically restrain residents with excessive frequency compared to many similar facilities that use effective behavioral interventions and have reduced or even eliminated

mechanical restraints from individuals' behavior programs. *See* Matson Tr. 1118:4-1120:22, 1126:7-18; Manikam Tr. 3157:5-3163:3; *see also* Cooper Tr. 2425:21-2426:1 (CHDC psychological examiner never needed to create a restraint program when working at University of Arkansas Medical School), 2427:14-20 (never attended professional conference or continuing education class that discussed use of restraints such as the papoose board); Warren Tr. 4721:1-4722:4 (papoose board and restraint chairs not used by any mental hospitals where Defense psychiatrist practices).

398. CHDC restraint data are unreliable and, while official numbers are extremely high, they likely understate the amount of CHDC's actual restraint use. Matson Tr. 1125:17-1127:24 (Problems with inconsistent data reporting include separate treatment of high restraint individuals.), 1260:19-1261:6 (conflicting reporting on emergency restraints), 1315:14-1318:21 (CHDC restraint data not informative); Manikam Tr. 3159:6-3160:6 (CHDC staff report data depending on various restraint categories that make little difference in terms of restrictiveness.); *see also* Reddig 2085:21-2086:25 (reporting varies depending on how facility chooses to classify restraint, *e.g.*, one piece jumpsuit used as "preventive restraint"), 2100:3-2103:10 (variety of tracking methods and omissions, such as the fact that name and time on behavior reports may not indicate person who filled out the behavior report or actual length of restraint use), 2108:18-22 (behavior reports used to record restraints and associated behaviors themselves can include all types of issues besides behaviors); Cooper Tr. 2462:1-2466:11 (CHDC uses a variety of different methods for tracking and reporting different types of restraint), 2473:20-2474:18 (differences between restraint categories are unclear; restraints can be used on an emergency basis even if resident does not have a safety plan governing restraint use); *see e.g.*, US Exs. CR-1, 627 (2007

CHDC memo directing that individuals with frequent restraint use should no longer have a behavior report for each restraint form).

399. CHDC arbitrarily uses restrictive measures that staff do not even count as restraints, such as personal holds (*i.e.*, staff physically holding resident's limbs or other body parts), and "separation to allow calming," with little clinical oversight or monitoring for the appropriateness of these restraints or their impact on the individual and his/her behaviors. *See, e.g.*, Manikam Tr. 3124:17-3126:14 (personal holds are not carefully tracked and safeguarded based on what can be widely varying levels of restrictiveness for the particular hold used); Manikam Tr. 3217:7-22 (staff bar residents from leaving rooms, an unmonitored practice that is functionally similar to "seclusion"); Adams Tr. 1842:23-1844:20 ("separation to allow calming" criteria so vague that staff may effectively restrict resident to room); Matson Tr. 1144:3-1145:6 (inadequate 1 to 1 supervision used rather than adequate behavioral treatment). Moreover, CHDC's chief psychologist was not even familiar with the various types of personal holds that staff can use at CHDC. Reddig Tr. 1983:16-1984:10. Since CHDC does not track these measures as restraints, CHDC's actual number of restrictive measures each month is even higher than CHDC reports.

400. While there are difficulties comparing restraint use across populations or facilities, statistical comparisons reinforce conclusions of experts Dr. Matson and Dr. Manikam that CHDC's restraint use is excessive and inappropriate. Matson Tr. 1181:20-1182:12 (3-4 residents with restraint programs in a facility housing 300-400 residents in expert's practice, versus "70 and 80" self-reported restraint programs at CHDC, which does not include other restraints actually in use at CHDC, such as lap trays, seat belts, or chemical restraints), 1133:20-1134:15 (national study recommending minimizing use of restraints); Manikam Tr. 3157:5-3163:16 (general discussion of CHDC's restraint use), 3213:25-3215:4 (comparing far more serious

behaviors treated in other facilities that do not rely on restraints as much as CHDC does), 3216:12-19 (discussing restraint-free or nearly restraint-free facilities); US Ex. 691.

3) CHDC Utilizes Restraints Without Safeguards, Oversight, and Clinical Review Required by Professional Standards.

401. CHDC's lack of important restraint safeguards further illustrates how CHDC restraint practices substantially depart from generally accepted professional standards. Matson Tr. 1122:13-1124:12 (poorly defined terms and policies), 1128:17-1131:4 (lack of post-restraint reviews); Manikam Tr. 3075:4-3077:13; US Ex. 692; Reddig Tr. 1983:16-1984:10. CHDC policies and practices do not appropriately define what CHDC considers a "restraint," or other important terms associated with the use of restraint. Matson Tr. 1122:13-1124:12. Further, CHDC's restraint programs fail to include clear descriptions of behaviors during which staff can use the restraints. Matson Tr. 1122:13-1124:12 (lack of clear triggers puts staff "in a horrible position"). In addition, CHDC allows "Qualified Mental Retardation Professionals" ("QMRPs") to authorize the use of restraints, but CHDC's QMRPs have substantially lower qualifications than those in similar facilities. Matson Tr. 1063:4-25, 1129:24-1130:12; US Ex. 692 (Behavior Procedures policy.).

402. In virtually no instance do CHDC psychology staff clinically assess the circumstances that led staff to use the restraint or assess the impact that the restraint had on the individual or his behavior. Such clinical, post-restraint reviews are essential because they directly affect care. For instance, post-restraint reviews should include clinical evaluation of the incident, counseling for individuals traumatized by staff's restraint, and allow staff to promptly assess and evaluate the resident's condition. Matson Tr. 1128:17-1129:23; Manikam Tr. 3075:4-3077:4.

403. CHDC's restraint practices substantially depart from generally accepted professional standards of harm, causing residents harm and unnecessary risk of harm. *See generally* Matson Tr. 1120:15-22; Manikam Tr. 3160:23-3163:16.

C. CHDC Subjects Its Residents to Harmfully Inadequate Psychological Treatment.

404. Even though CHDC uses restraints on an extraordinarily wide scale, staff do not correspondingly provide treatment programs for a large number of residents with serious behavioral and habilitation needs. Matson Tr. 1116:11-1118:23; US Exs. 588 through 592, 598 & 617. Instead, unqualified psychological examiners (master's level practitioners) develop treatment plans that do not meet generally accepted professional standards because – (1) they take too long to be developed and implemented; (2) key components are located in different and often contradictory documents; (3) behavioral interventions are generic, with insufficient differentiation between individuals or across settings (*e.g.*, school versus housing area); and (4) critical components are missing from plans. *See* FOF Part VI.C-G; US Exs. 531 through 580, 603 through 604, 631 through 666, 687 through 690, 701-1 through 701-6. As a result of such deficiencies, CHDC residents suffer from serious behaviors without effective and timely treatment. *See* FOF Part VI.B-D; Matson Tr. 1084:12-1085:25; Manikam Tr. 3142:8-3145:3; *See generally* Appx.

1) CHDC Does Not Develop Treatment Plans for All Residents Who Need Them.

405. Nearly every CHDC resident has serious cognitive, communicative, and functional limitations. Most of CHDC's residents have a variety of behaviors that require behavioral management, such as self-injury, aggression, and pica (*i.e.*, eating inedible objects). Matson Tr. 1116:11-1118:23; US Exs. 588 through 592, 598 & 617.

406. CHDC's psychological services fail to meet the needs identified by CHDC staff themselves. As only 30-40 percent of CHDC residents actually have behavioral programs, either CHDC fails to provide services to many residents with serious behavioral problems, or CHDC staff are misclassifying a large number of residents through a substandard assessment process. *See* Matson Tr. 1116:11-1118:23.

2) CHDC Fails To Modify Residents' Behavior Plans Promptly in Response to Changing Needs.

407. Behavioral plans at CHDC are often static, and CHDC staff do not promptly re-evaluate and update behavioral plans based on significant changes in residents' conditions. Matson Tr. 1084:12-1085:25; Manikam Tr. 3142:8-3145:3 (detailing how delays result in non-alignment of assessments and treatment); *see, e.g.*, US Exs. 564, 567, 578, 580, 701-1 through 701-6. Generally accepted professional standards require that staff develop, implement, and monitor a modification to the residents' behavioral plans as soon as there is a change in behavior that requires a new intervention. *See generally* Matson Tr. 1084:12-1085:25; Manikam Tr. 3142:8-3145:3.

408. CHDC's own internal e-mails admit that the "time frame for safety plan implementation is terrible." US Ex. 611; *see generally* Appx. Staff also admit that residents experience long delays, sometimes "several months" in "getting changes approved for the safety plans." Cooper Tr. 2452:12-2453:7. CHDC staff almost "universally acknowledge[ ]" this delay problem. Cooper Tr. 2452:12-2453:7. For example, in the case of CA, it took seven months to implement a safety plan even though CA's behaviors were severe enough to require use of a papoose board, there were no significant changes in GB's treatment plan over the years, and staff did not implement TC's treatment plan for eight months after it was completed. *See* Appx. at 12, 21, 30.

409. Nor do CHDC's special staffings or incident review committees adequately address needed changes to resident plans, because those processes are not designed to make significant clinical changes to treatment based on up-to-date information. Cooper Tr. 2431:3-2432:6. A "special staffing is more like an addendum to the IPP than a change to the existing IPP." Cooper Tr. 2431:3-2432:6.

410. Even when CHDC psychology staff ostensibly assess or reassess residents (*e.g.*, identifying the functions of behaviors), staff do not properly incorporate the assessment results into treatment programs. Matson Tr. 1069:17-1072:15; Manikam Tr. 3124:7-14.

3) CHDC's Behavioral Treatment Program Is Too Disorganized and Convoluted To Ensure Appropriate Care.

411. Expert Dr. Matson concluded that CHDC's treatment process has some of the most significant deficiencies he has ever seen compared to the 39 centers that he has visited in 18 states over a period of 30 years. He found that CHDC's entire treatment process is disorganized, with different (and often inconsistent or contradictory) components of the behavioral programs located in multiple documents. Matson Tr. 1286:7-1289:14.

412. CHDC's jumbled system requires that direct care staff theoretically reference safety plans, Quick Reference Guides ("QRG's"), individual programs, positive behavior support plans, and other treatment documents when determining how to manage a resident's issues. This process is too convoluted to be effective. The psychology examiners themselves had "tremendous difficulty being able to explain the difference" between different behavioral program documents. Matson Tr. 1287:22-1288:18; *see also* Adams Tr. 1787:11-1788:17 (direct care staff are supposed to be familiar with multiple documents containing different components of the residents' behavioral programs).

413. CHDC staff do not implement the behavioral programs consistently across different settings (*e.g.*, in school and the living unit). Matson Tr. 1093:21-1097:2 (CHDC's staff overlook important considerations that affect the successful implementation of assessment and treatment programs across settings), 1106:9-1107:18; US Exs. 1197 through 1198, 1201, 1214, 1216 through 1217.

4) CHDC's Generic Behavioral Programs Cannot Meet Residents' Specific Behavioral Needs.

414. CHDC staff routinely use generic interventions to address resident behaviors that fail to account for the particular elements of the resident's behavior. Manikam Tr. 3139:25-3142:5. Professionals who understand "behavior principles understand[] that behavior is contextual." Manikam Tr. 3139:25-3142:5. Yet CHDC often uses generic interventions for residents. Staff do not differentiate between environmental settings (*e.g.*, when a resident is in their living unit versus school) when developing treatment. Similarly, staff use generic "blocking" interventions regardless of individual characteristics. Manikam Tr. 3139:25-3142:5; *see also* US Exs. 1197 through 1198, 1201, 1203, 1211, 1214, 1216, 1217 (Arkansas' Department of Education findings).

415. CHDC treatment programs lack critical components necessary for successful intervention, such as identification and interruption of precursors to aggressive behavior. Manikam Tr. 3138:15-3141:24; *see* US Ex 621 (policy on restraints, release criteria, and programming during restraint intervals). Precursor behavior signals impending, more obvious, aggressive behavior. For instance, a person may tense before making an aggressive motion. When a person exhibits a precursor to more serious behavior, the generally accepted minimum practice requires staff to interrupt the chain before the more serious behavior occurs. Yet, "nine

out of ten" CHDC plans do not even identify an individual's precursor behavior, so staff have no way "to intervene before the behavior is fully exhibited." Manikam Tr. 3138:15-3141:24.

416. In many cases, CHDC plans demonstrate staff's complete inattention to serious behavioral issues. *See generally* Appx. For example, SA's triggers for alleged self-injurious behaviors were not tracked or addressed; DB's plan identified no replacement behaviors or strategies for mitigating communication issues; MB had an inadequate psychological assessment and treatment planning for managing eating issues, etc. *See* Appx. at 21, 23, 26.

417. CHDC psychology staff also largely ignore their habilitative role when developing plans for residents (*i.e.*, helping to develop independent living skills). Matson Tr. 1103:3-1106:1 (importance of habilitation training in basic skills, such as toileting); *see also* Cooper Tr. 2459:17-2460:1 (examiner has never done habilitation training), 2456:19-20 (no psychosocial skills instruction); Adams Tr. 1778:15-17 (no programming for extreme food selectivity and rapid eating), 1793:15-1796:16 (psych examiner received no education or training on habilitation); Cooper Tr. 2456:5-12 (no programming for extreme food selectivity and rapid eating); Manikam Tr. 3101:7-3104:4, US Ex. 562-3 (no functional analysis to determine if resident MB may have rapid eating disorder before placement on modified diet).

418. The CHDC psychology staff are not even proficient with important behavioral terms of art, such as "treatment fidelity," and behavioral techniques such as "reinforcement," "shaping," and "chaining." *See* Matson Tr. 1074:11-1084:11; *see also* Adams Tr. 1781:3-1783:5; Reddig Tr. 2026:19-2028:19. Such concepts and techniques serve as the foundations for behavioral treatment and staff should employ them when crafting an individualized treatment plan, but CHDC staff have difficulties even describing these concepts and techniques, let alone applying them in practice. *See* Matson Tr. 1074:11-1084:11.

5) CHDC Staff Rely on Unnecessary Restraints Rather Than Effective, Positive, Psychological Interventions.

419. When staff utilize a resident safety plan that includes "planned restraints," CHDC has not required that staff also develop a positive behavioral support plan, which is a treatment document that includes less restrictive elements such as positive reinforcement and other evidence-based techniques to modify behavior. *See* Reddig Tr. 1945:21-1946:23, 1947:6-8.

420. CHDC's psychology treatment programs do not include necessary safeguards to prevent abuses of restrictive interventions. For example: CHDC taper criteria fail to meet minimum standards. Matson Tr. 1089:7-14, 1135:21-1137:23, 1150:22-1153:7, 1158:7-1160:9; *see e.g.*, US Exs. 561 (resident SA), 567 (resident TC) & 571-1 (resident RC); *see also* Adams Tr. 1801:20-1803:20 (equivocating on the role of taper criteria in decisions on restraint use and discharge). CHDC staff do not set effective, data-based criteria for when they expect to taper the use of restrictive interventions, and even when residents meet staff's arbitrary taper criteria, no expectation exists that staff then actually reduce medications or restraints. Matson Tr. 1089:7-14, 1135:21-1137:23, 1150:22-1153:7, 1158:7-1160:9.

421. Psychology staff were not aware of any policy specifying the minimum number of staff required when using restraints. *See, e.g.*, Adams Tr. 1846:8-17; Cooper Tr. 2473:1-5.

6) CHDC Uses Treatment and Assessment Processes That CHDC Staff Themselves Admit Do Not Meet Professional Standards.

422. CHDC adopted the current substandard assessment and treatment process after consulting with Dr. Kevin Walsh, a defense witness Defendants also used as a pre-trial psychology consultant. Dr. Walsh, however, is not a licensed psychologist. *See* Reddig Tr. 1962:16-1963:7; Walsh Tr. 5783:19-23, 6042:3-8.

423. CHDC's treatment approaches have never been subjected to peer review, formal study, or even studies by CHDC staff themselves to determine effectiveness. Reddig Tr. 2066:3-23.

424. Published, well-established, professional standards support Drs. Matson's and Manikam's expert conclusions regarding the deficiencies found at CHDC. For example, CHDC psychology staff admit that the Diagnostic and Statistical Manual of Mental Disorders IV ("DSM IV") represents the standard for conducting diagnosis and some of their assessments. Matson Tr. 1038:22-1039:19; Reddig Tr. 1973:2-12; Adams Tr. 1770:2-3 (acknowledging DSM IV is one of the standards in the field); Cooper Tr. 2429:5-7 (DSM IV "considered authoritative").

425. Defendants' own psychiatry consultant, Dr. Andrew Warren, cited to the "Expert Consensus Guidelines" ("ECG") as a source of professional standards. *See generally* Warren Tr. 4742:20-4755:2. These Guidelines, cited by Defense consultants, on their face require better care than found at CDHC. Those requirements include: using applied behavioral analysis, functional analysis, communication and environmental assessments, psychosocial interventions, "most specific DSM-IV TR diagnosis possible," behavior rating scales and psychometric tests, rigorous data analysis, re-assessment of diagnoses before medication modifications, and caution about continued use of medications when there is no proven utility. *See generally* Warren Tr. 4742:20-4755:2, 4759:13-22 (citing ECG as a standard).

426. The DSM IV, ECG, journal articles, and other standards in the field specifically echo the generally accepted professional behavioral techniques and assessment approaches outlined by experts Dr. Matson and Dr. Manikam. CHDC substantially departs from these generally accepted practices. *See generally* FOF Part VI.A-G; Warren Tr. 4742:20-4755:2, 4759:13-22.

427. Numerous examples illustrate the diagnostic and assessment problems at CHDC such as mismatches between diagnoses and interventions, interventions based on unsound assessments,

or continued use of ineffective interventions without reassessment of "rule out diagnoses." *See generally* Appx.

428. CHDC's failure to provide adequate behavioral assessment and treatment causes residents harm and unreasonable risk of harm. Matson Tr. 1178:4-1179:18, 1305:1-1306:24, 1312:9-1313:4; *see generally* Appx. This harm manifests itself in a myriad of ways, ranging from the loss of communication and independent living skills to the physical and psychological harm restraint use causes. Matson Tr. 1178:4-1179:18, 1305:1-1306:24, 1312:9-1313:4; *see generally* Appx.

D. CHDC's Psychological Assessment and Diagnosis Procedures Substantially Depart from Generally Accepted Professional Standards.

429. Psychological assessments serve as the foundation for psychological treatment. Matson Tr. 1004:7-1006:5, 1007:1-6, 1052:24-1054:15. One of the primary roles of a facility psychologist is to conduct assessments to determine an individual's capabilities and to identify the "function" (*e.g.*, motivating factor or trigger) for an individual's behaviors. *See, e.g.*, US Ex. 555 (CHDC psychological examiner job description).

430. Inaccurate psychology assessments prevent psychology staff from accurately identifying a resident's strengths and weaknesses or the cause of their behaviors. As a result, the staff cannot develop an appropriate treatment plan. Matson Tr. 1007:1-6, 1052:24-1054:15. CHDC's psychological assessment process fails to meet professional standards because it does not: (1) use reliable and effective assessment tools; (2) identify the function of maladaptive "target behaviors," (*i.e.*, a prescribed behavior identified for change); or (3) properly incorporate basic assessment information in the development of treatment programs. *See generally* FOF VI.D.

431. CHDC assessments of individuals' behavioral needs substantially depart from generally accepted minimum professional standards because psychology staff do not use, and in many

cases do not even know about, basic behavioral assessment instruments and techniques. Matson Tr. 1006:6-1030:10 (CHDC functional assessment of behaviors do not meet minimum standards), 1032:24-1040:8 (CHDC's cognitive and adaptive function assessments do not meet minimum standards with 42 individuals misclassified as more severely disabled than testing shows), 1040:9-1050:22 (poor assessment of psychopathology (*i.e.*, diseases of the mind) resulting in poor treatment and use of dubious diagnoses), 1052:24-1054:6 (processes are not evidence-based or scientific), 1054:7-1062:4 (data collection that underpins assessment and treatment does not meet professional standards of reliability and fidelity); *see also*, Reddig Tr. 1957:2-6 (CHDC Chief Psychologist admitting that he could not recall whether any of his staff use peer-reviewed tests); US Exs. 1197-1198, 1201, 1203, 1211, 1214, 1216, 1217 (Arkansas' Department of Education findings).

1) CHDC's Functional Assessment Process Is Completely Inadequate for Identifying the Causes of Resident Behavior.

432. CHDC's functional assessments lack many of the most critical elements of a clinically useful functional assessment. *See generally* Matson Tr. 1007:7-1024:24.

433. When treating a resident's behavioral challenge, generally accepted standards require psychology staff to define the maladaptive target behavior that is the focus of the behavioral intervention, so that staff can consistently identify and respond to the behavior. Matson Tr. 1019:3-19, 1024:25-1029:4, 1157:9-22; Manikam Tr. 3223:9-14, 3226:1-8. CHDC psychology staff do not understand the process for defining target behavior. Instead of crafting an objective description of the target behavior so that all staff can consistently identify and respond to it, CHDC psychology staff use vague, broad terms that do not allow for faithful implementation of behavior plans. Matson Tr. 1019:3-19, 1024:25-1029:4, 1157:9-22; Manikam Tr. 3223:8-14, 3226:1-3226:8.

434. After objectively defining the maladaptive target behavior, staff must assess the function of the behavior. Matson Tr. 1006:6-1030:10; *see* Manikam Tr. 3074:3-8, 3087:23-3138:6, 3148:11-19 (discussing examples of how failure to assess behavioral function impedes treatment).

435. CHDC's process, however, actually consists of a short "worksheet" that CHDC's Chief Psychologist, Dr. Reddig, admits is not as rigorous as a true "functional analysis." Reddig Tr. 1959:4-1961-8, 1967:6-9, 1968:15-1970:2. Moreover, this worksheet has never been peer reviewed or validated. Reddig Tr. 1959:4-1961-8, 1967:6-9, 1968:15-1970:2; Matson Tr. 1006:6-1030:10; Manikam Tr. 3074:3-8, 3087:23-3138:6, 3148:11-19; Adams Tr. 1776:17-25 (CHDC does not "use any standardized measure of functional assessment that is referenced in the professional literature."); Cooper Tr. 2428:7-21 (The functional assessment form used by CHDC has not been "validated in any professional journal of publication."). Still, CHDC staff use this simple worksheet as the primary means for assessing the function of behaviors across the facility. Reddig Tr. 1968:15-1970:2.

436. CHDC's functional assessment form asks staff to postulate what causes a behavior. This violates generally accepted professional standards, because extensive research demonstrates that what people "think causes something and what actually causes it when you actually do a systematic [functional] evaluation are often quite different." Matson Tr. 1024:15-24.

437. This functional assessment form does not require staff to consider factors professionals commonly recognize as contributing to behaviors, such as environmental conditions and histories of aggression between specific individuals. Matson Tr. 1172:12-1173:19; Manikam Tr. 3095:14-3097:2; *see, e.g.*, US Exs. 561-9 (NS fights) & 656 (ZS fights); *see also* Warren Tr. 4726:23-4727:1 (admitting that he saw no indication that CHDC's psychiatrist ever looks at patterns of

repeat injury by one resident against another). As a result, staff often do not consider basic interventions, such as separating individuals who do not get along, or moving individuals to smaller settings. Matson Tr. 1172:12-1173:19; Manikam Tr. 3095:14-3097:2.

438. When staff have identified the maladaptive behavior and determined its function, they should develop an intervention using that information. CHDC staff cannot implement interventions consistently, however, since target behaviors are often not clearly defined. This inconsistent application makes it difficult to determine which factors "are resulting in changes in frequency of behavior." Matson Tr. 1145:7-10, 1019:3-19, 1024:25-1029:4, 1157:9-22; Manikam Tr. 3223:9-14, 3226:1-3226:8.

439. Additionally, CHDC staff conduct a single functional assessment for all target behaviors instead of independently and separately assessing each behavior as required by generally accepted professional standards. Matson Tr. 1095:13-1096:16. Different behaviors may have completely different triggering conditions, so a single assessment will likely fail to provide adequate information. Matson Tr. 1095:13-1096:16.

440. The data that CHDC staff does collect when completing a functional assessment is not gathered scientifically. Matson Tr. 1017:21-1020:8 (CHDC does not use recognized scaling methods, scatter plots/graphing, or clear target behaviors), 1021:11-1022:13 (failure to ensure reliable data), 1145:7-1147:5 (lack of graphing and data analysis methods to differentiate behavioral factors); Manikam Tr. 3226:18-3227:6. In fact, "[e]ach individual psychological examiner pretty much designs their own data collection system." Matson Tr. 1065:23-1066:18, 1156:6-1157-2; *see e.g.*, US Ex. 554. This haphazard approach prevents CHDC from ensuring "continuity or standards or consistency" in care. Matson Tr.1065:23-1066:18. Without a standard scientific approach to data collection and analysis, CHDC staff assessments about the

function of resident behaviors are untrustworthy and clinically unsound. Matson Tr. 1017:21-1020:8, 1021:11-1022:13, 1065:23-1066:18, 1145:7-1147:5; Manikam Tr. 3226:18-3227:6; *see also* US Ex. 612 (staff reference to trying to generate more "data type" numbers after initiation of litigation).

441. The frequency of CHDC's functional assessments also substantially departs from generally accepted professional standards of care. *See generally* Matson Tr. 1156:9-1157:2. Instead of completing a new assessment any time a new maladaptive behavior appears, CHDC staff prepare functional assessments only about once a year when the interdisciplinary team meets. Reddig Tr. 1971:8-1972:3.

442. CHDC staff do not even apply the substandard worksheet functional assessment process when assessing children unless the child has a "safety plan that includes restraint usage." Adams Tr. 1790:16-1791:19.

2) CHDC Assessments of Cognition, Adaptive Function, and Pain Substantially Depart from Professional Standards.

443. CHDC's assessment of residents' level of cognitive and adaptive function (*i.e.*, level of developmental disability) does not meet generally accepted minimum professional standards in general, and also does not even produce results that are consistent with internal CHDC standards. Matson Tr. 1032:24-1040:8 (CHDC's cognitive and adaptive function assessments do not meet minimum standards, and even under CHDC's methodology, at least 42 individuals were misclassified as more severely disabled than testing shows). As a result, CHDC staff regularly misclassify residents' potential for skills training, such that residents may not receive appropriate habilitation activities, which lead to greater independence. Matson Tr. 1034:10-1035:1.

444. Staff combine cognitive and adaptive test results instead of evaluating cognition based on the standards established by the American Psychiatric Association's DSM-IV. This improper

combination causes CHDC staff to frequently misclassify residents as having more severe cognitive deficits than the residents actually have. Staff then rely on the incorrect results and provide residents with an inappropriate level of care. Matson Tr.1038:18-1040:5.

445. CHDC psychology staff should conduct assessments of communication issues, separate from the adaptive function assessment responsibilities of other CHDC departments. At facilities like CHDC, nearly "everybody has a communication problem," and many standardized tools exist that allow psychology staff to address residents' communication needs from a behavioral perspective. Matson Tr. 1051:5-1052:23. Yet, at CHDC, the psychology staff do not play a meaningful role in assessing resident communication needs, even when a resident exhibits maladaptive behaviors to communicate needs they cannot otherwise express. *See* Matson Tr. 1051:5-1052:23, 1079:7-1082:1 (example of failure to teach alternative communication skills and address communicative function of behavior for residents who exhibit aggression to communicate needs); Reddig Tr. 1988:8-21(chief psychologist unable to identify or address communication assessments because they are outside of his expertise or scope of responsibility).

446. CHDC psychology staff also do not adequately assess pain issues that contribute to behaviors. Matson Tr. 1005:3-1006:5, 1030:11-15 (CHDC staff not assessing pain); *see, e.g.*, Adams Tr. 1778:3-14 (no formal instrument "to track pain or how people are experiencing pain"), Cooper Tr. 2440:4-5 (does not "use any kind of pain tracking instrument"); *see also* Reddig Tr. 1950:21-1951:17 (psychologist accepting no role in pain monitoring).

447. CHDC staff do not assess residents' cognitive and adaptive functioning frequently enough to meet residents' needs. Matson Tr. 1036:22-1037:15. CHDC largely stops performing assessments of individuals' cognitive and adaptive functioning once a resident reaches

adulthood, though function continues to change past adolescence and residents' training and treatment needs may shift. Matson Tr. 1036:22-1037:15.

3) CHDC Staff Fail To Use Assessment Instruments That Meet Professional Standards.

448. CHDC's psychology staff should be familiar with, and use, professionally accepted psychological instruments to assess individuals with developmental disabilities, because tests validated for a population are more likely to be accurate or useful. Matson Tr. 1068:13-1069:6, 1032:24-1050:23. Instead, CHDC staff do not use, and indeed are unaware of, peer-reviewed diagnostic instruments professionals use in their field. *See, e.g.*, Adams Tr. 1777:1-1778:14; Cooper Tr. 2439:20-2440:5; Reddig Tr. 1957:2-6, 2038:24-2040:6. CHDC's Chief Psychologist admitted that he could not recall any of his staff using peer-reviewed tests. Reddig Tr. 1957:2-6, 2038:24-2040:6. The failure to use these trusted instruments is itself a violation of generally accepted professional standards, but CHDC's problem is even worse – there is no consistency or standard for the use of those instruments that are currently available at CHDC. *See generally* Matson Tr. 1032:24-1050:23.

449. CHDC does not use a standardized instrument for diagnosing mental illnesses that may be comorbid (*i.e.*, co-extensive) with the individual's developmental disability. Matson Tr. 1040:9-1042:17.

450. CHDC staff also incorrectly apply the few valid/professionally acceptable tests they actually use. Specifically, CHDC staff wrongly use the same test instruments for various groups at CHDC, notwithstanding that these tests have not been scientifically validated or shown to be "psychometrically sound" (*i.e.*, normed for the characteristics of the group actually being tested) for the particular group. Matson Tr. 1035:10-1040:1 (Slosson test inappropriately used as clinical assessment of intellectual function across populations with varying levels of function),

1164:19-1165:9 (ICAP inappropriately used for functional assessment), 1099:16-1100:5 (inappropriate use of Slosson test on group of residents with deafness); *see also* Priest Tr. 6668:21-24 (ICAP used at CHDC only because some State "bureaucrats" thought test would provide a convenient score for determining level of appropriate service). In fact, the Arkansas Department of Education specifically cited CHDC for using the "Slosson" brief intelligence test inappropriately on individuals who are deaf. Matson Tr. 1099:13-1100:3; US Ex. 1203.

4) CHDC's Unreliable Assessments Generate Unsupportable Psychiatric Diagnoses That Substantially Depart from Professional Standards.

451. CHDC does not base many of the "diagnoses" that form the foundation of CHDC's psychiatric disorder treatments on scientific or clinically defensible assessments. Matson Tr. 1189:11-19, 1040:9-1050:22 (CHDC does not use validated diagnostic tools, and its substandard methodology for assessing psychopathology results in unsupportable diagnoses and inadequate treatment); US Exs. 553-1 (client census summaries) & 662 (pica list).

452. Rather than using a "rule out diagnosis" that allows a clinician to determine systematically whether a diagnosis is appropriate over time, CHDC uses its own informal procedure, one that often produces ostensibly persistent, but unreliable diagnoses, that then become the basis for inappropriate treatment. Matson Tr. 1040:9-1050:20. Defendants did not provide any example where a diagnosis was clearly identified as "rule out" and then carefully re-assessed with further testing and evaluation. *See* Warren Tr. 4725:7-22 (Defense psychiatrist acknowledging that in field, professionals use the term "rule out" or "provisional diagnosis" but never could not recall seeing these terms used by CHDC's own staff).

453. Numerous examples of poorly substantiated diagnoses show CHDC's substandard diagnostic procedures, and raise serious concerns about the appropriateness of CHDC's psychological and psychiatric interventions. *See, e.g.*, US Exs. 631 (Resident EA – psychotic

disorder due to microcephaly), 632 (Resident MLA – mental retardation and personality change due to hydrocephalus), 633 (Resident RDA – obsessive compulsiveness in a profoundly retarded resident who lacks the level of cognition necessary to have such a disorder), 634 (Resident WLB – myopia/personality change due to microcephaly), 640-1 (Resident JS combination of obsessive compulsive disorder with both dementia and schizophrenia, which are in many ways incompatible with the former); *see also* Warren Tr. 4725:4-6 (Defendants' psychiatric consultant has never himself made a diagnoses of "psychotic disorder due to microcephalus").

E. CHDC's Substandard Data Collection Is Unreliable.

454. CHDC psychology staff fail to properly collect and utilize reliable, objective data for assessment, diagnoses, and ultimately treatment. *See generally* Matson Tr. 1017:21-1020:8 (CHDC does not use recognized scaling methods, scatter plots/graphing, or clear target behaviors), 1021:11-1022:13 (failure to ensure reliable data), 1145:7-1147:5 (lack of graphing and data analysis methods to differentiate behavioral factors), 1056:15-1062:4 (no reliability or treatment fidelity measures), 1064:1-1065:19 (staff use of unreliable, after-the-fact, "data type" numbers and ad hoc data collection forms); Manikam Tr. 3226:13-3227:6 (none of the functional assessments reviewed included necessary data collection, reliability checks and other data analysis); *see also* Adams Tr. 1805:9-15 (no statistical tools or normalizing performed on data); Cooper Tr. 2428:3-6 (examiner has never heard of data observation sheets used by other staff at CHDC); Warren Tr. 4718:9-25 (trend lines and scatter plots are used by community psychology provider that Defendants' consultant works with in his own practice); Priest Tr. 6629:8-17, 6630:19-6631:3 (admitting psychology staff limited to essentially a paper review in their oversight of data collection by direct care staff); US Ex. 612 (psychology department e-mail calling for generation of "data type" behavioral numbers issued only in 2009).

455. Behavior plans should be assessed on their effectiveness and this, in turn, is measured by reference to behavior data. Conversely, at CHDC, only about 18 percent of the behavioral programs include graphs of behavioral data. Manikam Tr. 3152:12-20. Even when CHDC uses graphs, the graphs are typically just simple bar graphs, without even trend lines or other statistical analysis necessary to identify interventions' effects on, and change to, behaviors. Manikam Tr. 3152:12-3153:12; *see also* Warren Tr. 4718:9-25 (trend lines and scatter plots used by community psychology service provider in Defendants' consultant's own practice).

456. When they do record some data, CHDC staff track and focus on the wrong elements. For example, when assessing the effectiveness of treatment on behaviors, CHDC historically emphasizes tracking incidents of restraint, instead of plotting the core behaviors themselves. Matson Tr. 1067:2-1068:12; US Ex. 682. Restraint use is not an accurate means of tracking individual progress, as restraints can decrease even as behaviors increase. Matson Tr. 1067:2-1068:12; Manikam Tr. 3152:4-3155:12.

F. CHDC's Psychology Services Substantially Depart from Generally Accepted Professional Standards Because CHDC Lacks Sufficient Psychology Staff with the Education, Training, and Experience Required for the Treatment of Individuals with Developmental Disabilities.

457. CHDC psychology services fail to meet resident's needs, because the psychology department's staff lack the critical education, training, and experience required to provide the type of treatment CHDC residents require. Manikam Tr. 3081:17-3084:10; Matson Tr. 1182:17-1187:16; *see* FOF Part VI.F.

458. Generally, the CHDC psychology staff's education, experience, and training leaves them unprepared to assess and treat individuals with developmental disabilities or the types of behavioral issues found at CHDC. Manikam Tr. 3081:17-3084:10; Matson Tr. 1182:17-1187:16; US Exs. 556, 557, 607, 614; *see also* Adams Tr. 1765:4-1769:23 (testimony admitting

examiner's limited training, experience, and exposure to professional activities); Cooper Tr. 2422:19-2427:22 (same); Priest Tr. 6621:23-6626:21, 6667:1-8 (senior examiner with independent practice privileges unfamiliar with basic terms and admitting limits to training and experience).

459. When providing clinical psychological care, CHDC relies almost entirely on poorly supervised, master's level practitioners, who in many cases are unfamiliar with basic concepts and terms used in the field of applied behavioral analysis. These master's level practitioners conduct assessments and behavioral treatment that should normally be handled by doctorate level psychologists, or others with similar, extensive training and experience. Manikam Tr. 3081:17-3084:10; Matson Tr. 1182:17-1187:16.

460. CHDC's master's level practitioners ("psychological" or "psych" "examiners") lack the education, experience, and training needed to assess and treat the individuals with developmental disabilities with the behavioral issues found at CHDC. Most of the examiners possess a "secondary [psychology] license," a status that most other states do not recognize. Matson Tr. 1182:17-1187:16; US Exs. 555 through 557, 607 & 614.

461. CHDC does not employ enough qualified psychology staff with doctorate level training. Matson Tr. 1183:18-1190:25; Manikam Tr. 3084:1-10. CHDC employs only one doctorate level psychologist to provide clinical supervision for its psychology department. This supervisor, Chief Psychologist Dr. Carl Reddig, has a doctorate in counseling education. Dr. Reddig does not have the type of education, experience, and training needed to assess and treat individuals with behavioral issues at CHDC. Matson Tr. 1183:18-1190:25; Manikam Tr. 3084:1-10.

462. American Psychological Association policy states that a person must have a doctorate degree to be a licensed psychologist. Matson Tr. 1184:14-1185:23. Therefore, CHDC "psych examiners" cannot even hold themselves out to the public as "psychologists."

463. Even under Arkansas's standards, four of CHDC's psychological examiners cannot practice independently. Reddig Tr. 2099:9-11, *see also* Glenn Tr. 6689:11-16 (six CHDC psychological examiners practice independently).

464. Notably, psychology staff at CHDC have little exposure to practices outside of Arkansas. *See generally* Adams Tr. 1765:4-1769:23; Cooper Tr. 2422:19-2427:22; US Exs. 556, 607 & 614. For a number of the psychology staff, their first, and often only, significant work experience was at CHDC. The Chief Psychologist himself rarely participates in significant professional activities – such as publishing in professional journals or attending national conferences. Reddig Tr. 1942:22-1943:22, 1977:14-20.

465. Residents in a developmental center receive such placement primarily "because of problems in learning." Matson Tr. 1002:20-1004:6. In an ICF/MR, treatment should therefore focus on resident training. More specifically, treatment for individuals with developmental disabilities should target "issues such as communication training, training in terms of independent living skills," and training on skills that would help reduce aggression, self-injury, and other challenging behaviors. Professionals generally classify the relevant psychological techniques used to train individuals with developmental disabilities as "operant conditioning" or "applied behavior analysis." Matson Tr. 1002:23-1004:6.

466. Because of communication and cognitive issues, CHDC residents need to receive training with methods based on applied behavioral analysis. Most of the psychology staff, however, hold degrees in counseling psychology, education, or another field that does not provide sufficient

background in applied behavioral analysis; nor do such degrees typically include training on developmental disabilities in general. Matson Tr. 1186:15-21; *see also* Adams Tr. 1767:5-12 (counseling not done as much in current position because of communication issues); Cooper Tr. 2422:24-2423:14 (psychological counseling not normally requested or provided at CHDC).

467. CHDC psychological staff do not have a solid understanding of basic terms and techniques used in applied behavioral analysis and for the treatment of individuals with developmental disabilities. Matson Tr. 1072:6-1084:11 (discussing concepts such as "reliability," "treatment fidelity," "reinforcement," "shaping," "chaining," "replacement behaviors," and the "ABC['s]" of behaviorism); Manikam Tr. 3221:11-22 (direct interviews of psychology staff showed they do not understand basic terms); *see also* Adams Tr. 1781:3-1783:5 (CHDC staff do not use or even recognize various behavioral techniques); Cooper Tr. 2432:23-2433:17 (examiners use no standards to guide identification of reinforcers); Priest Tr. 6621:23-6626:21, 6667:1-8 (admissions regarding senior psych examiner training and experience); Reddig Tr. 2026:4-2030:15, 2037:2-4 (offering definitions of key concepts that differ from his own staff's definitions); *see generally* Appx. (examples of poor behavioral care include residents CA, SA, DB, GB, HB, MB, TB, CC, RLC, RC, TC, JD, KF, BH, KH, PH, JM, BLR, WR, JS, NS, ZS, LW, MW).

468. Dr. Reddig himself admits that not one of his psychological examiners is qualified to do a functional analysis, which, if done in accordance with generally accepted professional standards, serves as an essential foundation for treating an individual's behavioral issues. Reddig Tr. 2098:12-2099:1; *see also* Matson Tr. 1007:1-1014:24.

469. Making sure staff actually implement written programs serves as a basic component of any treatment system; yet CHDC does not have these required formal "treatment fidelity"

measures. Matson Tr. 1060:4-1062:4; *see also* Reddig Tr. 1991:15-1992:1 (admitting no formal treatment fidelity measures).

470. CHDC direct care staff do not receive adequate "competency training" to ensure that they know how to accurately implement and track behavioral programs. Matson Tr. 1131:5-1132:2; Manikam Tr. 3081:8-16, 3082:4-3083:22; US Exs. 582 & 583. "Competency training," where staff perform tasks and show understanding, is an essential component for training staff to implement behavioral programs. Manikam Tr. 3081:8-16, 3082:4-3083:22. At CHDC, however, direct care staff basically receive only two weeks of training, and then take a written test. Matson Tr. 1131:14-1132:2; US Exs. 582 & 583. This short, non-competency-based training, is not nearly sufficient to ensure that direct care staff know how to implement behavioral programs. Matson Tr. 1131:5-1132:2; Manikam Tr. 3081:8-16, 3082:4-3083:22; *see also* Cooper Tr. 2471:12-22 ("floaters" do not receive even multiple choice test).

471. CHDC psychology staff repeatedly made facially dubious statements, such as claiming that their data is a "hundred percent reliable," "no one was injured as a result of restraints in the facility," and there is no way to manage out-of-bounds behavior with operant conditioning. Manikam Tr. 3129:25-3132:7; *see also* US Ex. 691 (broad study noting dangers of using restraints). Such statements show serious gaps in training and experience.

472. Despite repeated notice from the United States and other outside auditors, CHDC psychology staff have not made necessary efforts to self-correct their substandard practices. There are a variety of means of ensuring that psychology staff obtain an adequate "background in applied behavior analysis" including sending staff to other facilities to do a "practicum" for several months or bringing qualified behaviorists to provide training. Manikam Tr. 3220:3-

3221:10. During the trial, Defendants never introduced evidence indicating that they have even attempted such basic remedial measures.

473. Psychology staff have not conducted any needs assessment to clearly determine the level of staffing necessary to serve individuals of CHDC, where almost 300 residents have dual diagnoses and 171 have significant behavioral issues. *See generally* Reddig Tr. 2067:19-2072:8 (admitting lack of effort to evaluate or address variety of deficiencies at CHDC).

G. CHDC Does Not Provide Psychology Staff with Adequate Clinical Supervision.

474. CHDC does not provide the level of professional oversight which could mitigate problems with psychology staff qualifications. A single, doctorate level psychologist theoretically oversees the psychology department. In practice, however, the Chief Psychologist provides little clinical oversight. Moreover, the Chief Psychologist himself does not have the level of education, training, and experience required to treat many of the residents. *See generally* Matson Tr. 1183:1-1187:12 (discussing level of training expected for a psychologist working with CHDC's population, which would include both extensive course work and relevant clinical experience); *see* FOF Part VI.F-G.

475. Since June 2004, Dr. Carl Reddig, CHDC's Chief Psychologist and only doctorate level practitioner, has overseen CHDC's psychology department. Matson Tr. 1188:16-1190:25; Reddig Tr. 1936:20-1937:24; Adams Tr. 1784:3-7.

476. Dr. Reddig received his educational degree from the education department of a university, not the psychology department, and his background lacks extensive training on applied behavioral analysis or the treatment of individuals with developmental disabilities. *See* Reddig Tr. 1940:13-18 (no coursework on applied behavioral analysis), 1940:19-1941:1 (only internship was at CHDC).

477. At the time of his deposition, Dr. Reddig could not identify any reference books or treatises for his field. Reddig Tr. 1977:6-24.

478. Dr. Reddig has not attended any professional conference except one, held by CHDC itself in the last five years. Reddig Tr. 1943:18-22.

479. No one supervises Dr. Reddig clinically. Reddig Tr. 1942:19-21.

480. Dr. Reddig does not typically carry a clinical caseload, so psychological examiners provide nearly all clinical care. *See* Reddig Tr. 1937:9-15.

481. Dr. Reddig spends only about two to four hours a week in the living units. Reddig Tr. 2015:4-11. This level of doctorate staffing is completely inadequate given the CHDC residents' needs. Matson Tr. 1183:18-22.

482. Since the psych examiners do not have doctorate degrees required for licensing, they cannot hold themselves out to be psychologists and are instead considered the "primary treating psych examiners." Reddig Tr. 2018:14-22. At the same time, Dr. Reddig does not consider himself to be the primary treating psychologist for any CHDC resident. Reddig Tr. 2018:14-22. In other words, no CHDC resident has a primary treating psychologist.

483. The Chief Psychologist exercises limited oversight over the examiners, with little actual substantive clinical review of their work. For example, Dr. Reddig does not generally review the cognitive assessments, functional assessment sheets, "strategies," or behavioral data the psych examiners compile. Reddig Tr. 2014:18-21, 1990:5-16; Adams Tr. 1786:1-18; Cooper Tr. 2447:24-2448:17. One psychology examiner could only recall Dr. Reddig making "typo changes" when he reviews her work. Cooper Tr. 2447:15-23.

484. Even though every person at CHDC is on his department's caseload, Dr. Reddig admits he does not actually review every Individual Program Plan - one of the most important treatment documents generated at CHDC. Reddig Tr. 2015:1-3, 1937:18-21.

485. Dr. Reddig does not participate meaningfully in team treatment planning, including IDT's responsible for reviewing treatment plans, the Human Rights Committee ("HRC") that reviews restraints and restrictive measures, or the Incident Review Committees ("IRCs") that are responsible for reviewing behavior reports and incidents. US Ex. 602 (Incident Review Committee membership list); Reddig Tr. 1956:2-3 (no participation in IDTs), 1980:23-1981:9 (no participation in HRC team), 2005:12-2006:18 (no participation in IRCs).

486. Dr. Reddig left CHDC for a few months in 2010, with staff assuming he had left permanently, before returning to his old position. *See* Adams Tr. 1784:3-1785:25; Cooper Tr. 2444:10-2445:20; Reddig Tr. 1937:25-1938:18.

487. During this period when the Chief Psychologist position was apparently vacant, Dr. Wyrick served as acting clinical supervisor, though he was based at the Booneville Human Development Center, and testifying psychology examiners only saw him one to three times during the entire period he was acting as Chief Psychologist. Adams Tr. 1784:3-1785:25; Cooper Tr. 2444:10-2445:20. While he was clinical director, the staff were even more poorly supervised than when Dr. Reddig was serving as Chief Psychologist. *See* Adams Tr. 1784:3-1785:25; Cooper Tr. 2444:10-2445:20.

488. CHDC does not have important standardized procedures, rendering quality assurance, clinical oversight, and data comparisons unreliable. Numerous examples of this serious deficiency exist, such as a lack of consistency in the use of basic terms and a general absence of formal training and quality assurance mechanisms. Cooper Tr. 2452:4-8 (no standard definition

of "physical injury"); Matson Tr. 1025:10-1027:10 (problematic definition of "aggression"); *see* Reddig Tr. 1950:21-1952-23, 1953:5-1955:3 (Chief Psychologist plays little role in overseeing compliance with various CHDC policies), 2000:9-16 (no formal mechanism to ensure staff compliance with written safety plans, *i.e.*, "treatment fidelity"), 1992:2-1994:3, 2002:16-2003:25 (data collection process relies largely on discretion of low level staff when filling out behavior reports and similar documents), 2008:5-16 (no formal staff training on how to report antecedent conditions), 2014:1-10 (Chief Psychologist does not train staff on restraint use), 2009:4-2011:16 (no formal quality assurance system to monitor psychology and direct care staff), 2017:11-19 (Chief Psychologist not familiar with facility injury tracking process); US Exs. 558 (CHDC psychology policies), 594 (behavior emergency procedures form) & 622-1(CHDC restraint policies).

VII. CONCLUSIONS OF LAW – PSYCHOLOGY AND BEHAVIORAL SERVICES

Defendants harm CHDC residents with psychology and behavioral services that violate residents' federal rights to freedom from unreasonable restraints, protection from serious harm, and psychological treatment in the most integrated setting appropriate to their individual needs. *Youngberg*, 457 U.S. at 315-18; *see also* Part III, *supra*. CHDC's psychology and behavioral services fail to provide psychological services necessary to meet the minimum treatment and habilitation needs of CHDC residents.

A. CHDC's Psychological and Behavioral Services Violate Residents' Constitutional Right to Habilitation and Treatment.

Defendants harm residents with substandard psychological and behavioral services that unlawfully rely on unqualified staff who fail to professionally assess and treat CHDC residents in order to meet their minimum psychological and behavioral needs. CHDC's substandard

treatment of residents so substantially departs from generally accepted professional standards, that the CHDC psychological and behavioral management program violates the Constitution.[1] *Youngberg*, 457 U.S. at 323; *see also* Part III, *supra* (discussing federal statutory right to treatment in most integrated setting).

First, CHDC does not have sufficient professional staff, qualified by training, education, or experience, to provide psychological and behavioral services at CDHC. *Youngberg*, 457 U.S. at 323 n.30. Instead, CHDC relies heavily on inadequately trained psychology "examiners" and direct care staff to develop, implement, and monitor programs that require a higher level of skilled practitioner to meet generally accepted professional standards. No one disputes that these staff are treating CHDC residents with often complicated conditions requiring specialized care. The Supreme Court has clearly required, however, that treating professionals must possess the qualifications necessary to provide the care for which they are responsible. *Id.* Simply meeting state licensing standards should not be considered automatically sufficient under federal law, especially in a case involving the United States' direct enforcement of individuals' federal rights. Here, CHDC psychology examiners lack the education and experience required to utilize behavioral management alternatives to restraints. Adequate treatment for individuals with developmental disabilities requires the use of specialized techniques, whose effectiveness is

[1] Professional decisions about a resident's services must be based upon the individuals' needs, not available services or administrative convenience. *See Ohlinger v. Watson*, 652 F.2d 775, 779 (9th Cir. 1981) ("Lack of funds, staff or facilities cannot justify the State's failure to provide appellants with that treatment necessary for rehabilitation."); *see also Thomas S. v. Flaherty*, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988) ("Professional judgment probably was not exercised if it was modified to conform to available treatment rather than appropriate treatment.") (internal citation omitted); *Lelsz v. Kavanagh*, 629 F. Supp. 1487, 1495 (N.D. Tex. 1986) ("Evidence that the professional judgment was made to conform to what was available may indicate that the judgment was a substantial departure from accepted professional judgment, practice or standards.") (internal quotations omitted).

supported by bodies of research. CHDC staff lack training and familiarity with these techniques and supporting research. The implementation of these techniques requires understanding of underlying concepts and terms of art. Unfortunately, admissions and case examples repeatedly demonstrate that CHDC examiners lack the necessary understanding for many of the terms and concepts that they are supposedly using to manage challenging behaviors. Additionally, CHDC allows some examiners, who cannot practice independently even under state law, to operate with no effective clinical supervision. CHDC employs only one doctorate level practitioner in the entire psychology department, and given the number of residents needing treatment, this level of clinical oversight is facially problematic. Moreover, the only doctorate practitioner at CHDC is himself unfamiliar with many of the basic concepts and tools professionals use in the field. His review of clinical treatment is mostly a paper review, not a clinical one. Defendants cannot claim to be meeting the *Youngberg* "professional judgment" standard when they literally do not employ enough qualified professionals to make such judgments. By themselves, CHDC's staffing and supervision deficiencies prove that the Defendants cannot be meeting their obligation to provide constitutional treatment.

Second, CHDC psychological and behavioral services violate the Constitution because staff regularly fail to conduct appropriate assessments and diagnoses of individuals in their care. *Youngberg*, 457 U.S. at 318-23. The Defendants do not meet constitutional standards just because a person with a license made a decision. To satisfy the standard, the decision must actually reflect "professional judgment," a legal term of art. *Id.* at 322-23. At minimum, evidence must show that such professional judgment was indeed exercised. *Id*. This standard is not met when a professional's decision substantially departs from generally accepted standards or practice. *Id*.; *see also Thomas S.*, 902 F.2d 250, 252-53 (4th Cir. 1990) (treating

professional's decision not conclusive in determining whether professional judgment was indeed exercised).

The routine use of idiosyncratic forms and assessment methods, that the Defendants' own staff admit have no proven scientific validity, is among the ways that CHDC staff's decision-making substantially departs from professional standards. Staff do not use, or are not even aware of, a host of scientifically validated instruments utilized by professionals in their field. When CHDC's idiosyncratic assessments occur, they are completed on a fixed schedule, rather than in response to observed changes in condition. The psychology staff take months to reassess and adjust treatment. As a result of CHDC's seriously flawed assessment process, many CHDC assessments of residents' cognition, adaptive function, psychopathology, pain, behaviors, and even physical condition, are seriously flawed.

Similarly, CHDC data collection and analysis, which is a foundation for assessment and treatment, substantially departs from professional standards. At CHDC, psychology staff do not understand some of the most basic concepts and techniques used by behaviorists to properly measure and evaluate target behaviors. This data issue is particularly problematic, because psychology staff serve as a linchpin for CHDC's facility-wide data collection and analysis process. The treatment teams and consulting professionals, such as CHDC's physicians and psychiatrist, use examiner data for making major changes in treatment.

In other words, even if the psychology staff meet minimum professional qualifications, their failure to establish the foundations for treatment using appropriate assessment instruments, forms, and data collection techniques, means that CHDC psychology services substantially depart from generally accepted professional standards. Without proper assessments, the staff cannot exercise "professional judgment" in an adequate, legal sense.

Third, CHDC's psychological and behavioral services substantially depart from generally accepted professional standards, because psychology staff fail to develop, implement, monitor, and update appropriate behavioral treatment plans to address the residents' serious needs. *Youngberg*, 457 U.S. at 315-23. Without effective treatment programs, staff rely on inappropriate restraints and other unsafe interventions. Staff take months to develop and implement treatment plans, which is simply too long given the dynamic environment at CHDC and the residents' changing needs. Additionally, once a plan is developed, CHDC has no effective procedures in place to ensure treatment fidelity, *i.e.*, procedures to ensure that staff are actually implementing plans in a consistent, organized fashion. Different and inconsistent interventions appear in a variety of documents in an individual's file, and staff training is not "competency"-based. The lack of up-to-date, effective treatment plans, that are implemented with fidelity, leads to unnecessary restraint and means that residents are not learning skills that promote independence.

As a result of these deficiencies in CHDC's psychological services, CHDC continues to fail to address residents' conditions, which allows residents to repeatedly harm themselves or others. CHDC's deficiencies go well beyond a simple disagreement between qualified professionals about diagnosis, assessment, or treatment. CHDC staff literally do not, and cannot, provide the minimum level of psychological treatment the Constitution requires.

B. CHDC Harms Residents with Unlawful Restraints That Violate the Fourteenth Amendment.

CHDC's restraint of residents as a "first option" violates the Constitution, causing residents psychological and physical harm. Professional standards require that treatment staff use seclusion and restraint as a last resort, only when an individual represents a danger to himself or others. *See Youngberg*, 457 U.S. at 316-18; *Society for Good Will to Retarded Children, Inc.*

v. Cuomo, 737 F.2d 1239, 1245 (2d Cir. 1984) (holding that all patients of mental health institutions have a right to freedom from undue bodily restraint); *Thomas S.*, 699 F. Supp. at 1189 ("Seclusion and restraint should only be used as a last resort."). CHDC's routine reliance on inappropriate restrictive measures, rather than on less intrusive and less restrictive applied behavioral techniques – such as teaching alternative communication strategies and developing effective reinforcement programs – violates the Fourteenth Amendment. *Youngberg*, 457 U.S. at 315-19; *Thomas S.*, 699 F. Supp. at 1189 ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior.").

CHDC's overreliance on restraints causes psychological and physical harm, as well as an ongoing serious risk of harm to the individuals CHDC subjects to these substandard restraints. *See, e.g.*, *Nat'l Ass'n of Psychiatric Health Systems v. Shalala*, 120 F. Supp. 2d 33, 45 (D.D.C. 2000) ("[S]evere psychological and physical injuries . . . can and do result from inappropriate use of restraints."). Such resident harm includes both the direct harm that residents incur from the actual restraint, as well as the harm that results from inadequately treated psychological conditions.

Federal regulations and statutes provide guidance on contemporary standards in this area. Federal regulations emphasize that restraints should be used only if "necessary," which means used only at a minimum, and expressly prohibit the use of restraints as a substitute for "active treatment." *See* 42 C.F.R. §§ 483.420(a)(6) & 483.450(b)(3). "Active treatment" requires that the State ensure that its treatment for individuals with developmental disabilities includes "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward (i) The acquisition of

the behaviors necessary for the [individual] to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status." 42 C.F.R. § 483.440(a). Yet CHDC's psychology program lacks even the basic components of a standard clinical treatment process, let alone providing anything resembling "active treatment."

In place of adequate habilitation and treatment to protect residents from harm, CHDC staff routinely and illegally utilize unnecessary, unsafe, and inappropriate mechanical and chemical restraints. *See Thomas S.*, 699 F. Supp. at 1189; 42 C.F.R. § 483.450. Both the types of restraints used, and the frequency of their use, violate constitutional limits. *See Thomas S.*, 699 F. Supp. at 1189; 42 C.F.R. §§ 483.420(a)(6) & 483.450(b)(3). CHDC employs a number of particularly egregious practices, including widespread use of the archaic papoose board and routine application of unnecessary restraints on children. CHDC's excessive use of mechanical restraints, again especially on children, has little, if any, support in either professional practice or the literature. Indeed, many states have prohibited their use on children. Defendants have exacerbated this unconstitutional harm by failing to adopt important safeguards on restraint use, such as conducting thorough, post-incident, clinical reviews. Some CHDC practices, such as personal holds and "separation to allow calming," lack even the attention and monitoring given to mechanical restraints.

Without substantial improvements in CHDC's unlawfully deficient psychological services, Arkansas will continue to unnecessarily institutionalize, segregate, restrain, and otherwise harm individuals with developmental disabilities. Defendants' continued failure to make even minimal modifications to existing psychological and behavioral treatment programs, such as providing relevant applied behavioral services, providing more communication

assistance to deaf residents, developing community-based behavioral programs, and developing practical habilitation plans, demonstrates Defendants' unlawful discrimination against individuals with developmental disabilities. *See also* Part III, *supra*.

TABLE OF CONTENTS – PSYCHIATRY AND MEDICAL CARE

VIII. FINDINGS OF FACT – PSYCHIATRY

489. CHDC's psychiatric services systemically and seriously deviate from generally accepted professional standards of care, with fatal or near fatal consequences. Mikkelsen Tr. 3573:22-21; Holloway Tr. 2620:17-2621:3. CHDC's failure to provide routine and emergency psychiatric services substantially departs from generally accepted professional practices. Holloway Tr. 2621:10-13; *see* FOF ## 504-637.

490. CHDC harms residents through subjecting them to psychiatric care that substantially departs from generally accepted minimum professional standards in several elements of psychiatric care. Specifically, CHDC harms residents by: needlessly exposing them to psychotropic medications with serious and dangerous side effects; using clinically deficient diagnoses to justify the unwarranted use of medications; engaging in unjustified medication practices (including prescribing medications to suppress another medication's side effects, in response to non-psychiatric environmental behaviors, and as chemical restraints); providing clinically deficient assessments of medication efficacy; providing untimely psychiatric assessments and follow up care; and failing to provide adequate clinical oversight, training, and support to CHDC's psychiatrist. *See* FOF ## 504-637.

A. Drs. Holloway and Mikkelsen Provided Credible Expert Testimony Detailing CHDC's Substandard Psychiatry Services.

491. Dr. Holloway has provided extensive psychiatric treatment to individuals with developmental disabilities in institutional settings for the last 18 years. Holloway Tr. 2485:24-2486:3; US Ex. 866. Dr. Holloway currently works as statewide psychiatric consultant to the State of Louisiana Department of Health and Hospitals Office for Citizens with Developmental

Disabilities. Holloway Tr. 2483:19-2484:3; US Ex. 866. Working at two developmental centers in Louisiana, Dr. Holloway trains psychiatric residents and medical students in the provision of psychiatric care to individuals with developmental disabilities. Holloway Tr. 2486:9-25; US Ex. 866.

492. Dr. Holloway is triple-board certified in psychiatry, child psychiatry, and forensic psychiatry. Holloway Tr. 2484:24-25; US Ex. 866. In 2009, Dr. Holloway successfully underwent board recertification in psychiatry in the law. Holloway Tr. 2488:21-23. She is an active member of many medical, psychiatric, and developmental disability associations. Holloway Tr. 2485:4-8; US Ex. 866.

493. Dr. Holloway has advised two states, Louisiana and Tennessee, regarding the psychiatric standards of care for individuals with developmental disabilities who live in residential training facilities. Holloway Tr. 2487:4-9, 2619:6-2620:13; US Ex. 866.

494. Dr. Holloway's review of CHDC consisted of: looking for policies and procedures regarding the provision of psychiatric care and interviewing CHDC staff involved in residents' psychiatric care (including the consulting psychiatrist, pharmacists, and some psychologists). Holloway Tr. 2499:16-2500:9. Dr. Holloway also selected and reviewed CHDC's psychiatric care for a reasonable sample of residents with a wide range of psychiatric needs. Holloway Tr. 2501:2-2502:2. In doing so, Dr. Holloway used the same methods of review that she has used in evaluating care as a consultant for the States of Louisiana and Tennessee. Holloway Tr. 2503:23-25.

495. Dr. Holloway based her assessment of, and conclusions regarding, CHDC's psychiatric care on the generally accepted professional standards on which she was trained when obtaining

three psychiatric board certifications; her career-long, extensive experience providing psychiatric care and designing care for individuals with developmental disabilities in institutions who are comparable to CHDC residents; and information obtained from medical academies, literature, peer-reviewed journals, textbooks, the psychiatry in the law recertification she recently underwent, formal residency rotation guidelines, evidence-based practices, peer review to which her clinical work recently has been subjected, and other sources. Holloway Tr. 2488:7-2489:17.

496. Dr. Mikkelsen is an adult and child psychiatrist who has been providing psychiatric services to individuals with developmental disabilities for 32 years. Mikkelsen Tr. 3562:25, 3567:18-22; US Ex. 751. Dr. Mikkelsen's particular expertise is the treatment of individuals with intellectual disabilities who have co-occurring psychiatric illnesses requiring pharmacological treatment. Mikkelsen Tr. 3564:23-3565:2, 3572:15-18.

497. Currently, Dr. Mikkelsen provides consultation services to the regional centers for the Massachusetts Department of Developmental Services that provide institutional care to individuals with developmental disabilities. These consultations involve specialized psychopharmacological questions for individuals with involved psychiatric problems or assessments of dangerousness and forensic assessments. Mikkelsen Tr. 3563:1-10; US Ex. 751. Dr. Mikkelsen also consults for the MENTOR network, a national provider of community residential services for persons with developmental disabilities. Mikkelsen Tr. 3563:10-16; US Ex. 751. Dr. Mikkelsen also offers second opinion consults on difficult psychiatric cases from various states. Mikkelsen Tr. 3565:13-17.

498. After medical school, *inter alia*, Dr. Mikkelson trained for two years in child psychiatry, which included a focus on individuals with autism spectrum disorders and pervasive developmental disorders. Mikkelsen Tr. 3565:19-3566:11; US Ex. 751.

499. Dr. Mikkelsen is board certified in adult psychiatry and child psychiatry. Mikkelsen Tr. 3566:13-15; US Ex. 751. Since 1980, Dr. Mikkelsen has served as an examiner in either the adult or child psychiatry board exams. Mikkelsen Tr. 3569:4-3570:8.

500. Following the completion of Dr. Mikkelsen's residency at the Yale Child Study Center, he founded an inpatient child psychiatry unit in a hospital in southern New Hampshire, served as the head of Child Psychiatry at the Massachusetts Mental Health Center, and helped initiate a postgraduate training program for the Harvard Medical School in treating psychiatric illnesses in persons with intellectual and other developmental disabilities. Mikkelsen Tr. 3567:23-3569:3. Dr. Mikkelsen has lectured both nationally and internationally, and has written over 100 professional publications and three books. Mikkelsen Tr. 3572:8-13; US Ex. 751. He is a member of the National Association for the Dually Diagnosed, the American College of Psychiatrists, and a distinguished fellow in the American Psychiatric Association ("APA"). He won the APA's Frank Menolascino Award for making significant contributions to the field of psychiatric care of individuals with developmental disabilities. Mikkelsen Tr. 3570:9-21, 3571:12-24; US Ex. 751.

501. Dr. Mikkelsen applied the generally accepted professional clinical standards he was taught at the Mayo Clinic, NIMH, Yale, and Harvard; the standards he has taught others; and the standards he has used clinically and that have been subject to outside peer review and evidence-based verification. Mikkelsen Tr. 3574:22-3575:5. Dr. Mikkelsen published a book in 2007,

The Rational Use of Psychotropic Medication in Individuals with Developmental Disabilities, that was peer-reviewed and outlines these generally accepted principles of psychiatric treatment. Mikkelsen Tr. 3575:8-3577:1.

502. In conducting his review of CHDC, Dr. Mikkelsen conducted two week-long tours of the facility approximately four weeks apart in summer 2009. During these tours, he interviewed, among others, CHDC's consulting psychiatrist, Dr. Callahan; CHDC's medical director; CHDC's director of psychology; a CHDC psychology staff member; and CHDC's on-call physician, Dr. Garry Stewart. Mikkelsen Tr. 3577:11-22. He also reviewed records, on-site and off-site, and visited facility living units. Mikkelsen Tr. 3577:22-3578:3.

503. The starting point for Dr. Mikkelsen's selection for his review of individuals' records was a spreadsheet provided by the Defendants identifying: CHDC residents by name in alphabetical order, whether the medications they were receiving are prescribed for behavioral purposes, their psychiatric diagnosis, and the individual's team. Mikkelsen Tr. 3580:4-3581:9; US Ex. 754-2. Dr. Mikkelsen identified and reviewed the records both of individuals who were low-utilizers of psychotropic medication and individuals who were receiving more psychotropic medications. Dr. Mikkelsen also looked at charts of individuals who had multiple psychiatric diagnoses and those who had psychiatric diagnoses that were unfamiliar to him or did not seem to fit other aspects of the individual's presentation. Mikkelsen Tr. 3581:7-21. This is a common approach to conducting reviews of psychiatric services in a facility such as CHDC. Mikkelsen Tr. 3583:9-15. Dr. Mikkelsen also reviewed records of individuals who died. Mikkelsen Tr. 3583:5-8. Dr. Mikkelsen reviewed approximately 75 charts in reaching his conclusions.

Mikkelsen Tr. 3596:17-22. This is approximately 20 percent of the caseload of persons receiving psychiatric care at CHDC. Mikkelsen Tr. 3597:12-15.

B. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Needless Exposure to Harmful Side Effects of Psychotropic Medications.

504. Nearly 300 of CHDC's approximately 500 residents receive psychotropic medications, and approximately half of those receiving psychotropic medications receive multiple psychotropic medications. Mikkelsen Tr. 3584:16-19.

505. CHDC residents have died and nearly died because of CHDC's systematic failure to avoid, detect, and mitigate common side effects of psychotropic medications. CHDC's failure to maintain an adequate system for detecting, monitoring, reporting, responding to, and documenting medication side effects, substantially departs from generally accepted minimum practices. Holloway Tr. 2621:19-23; *see* FOF ## 506-534.

506. Psychotropic medications can have serious and extensive harmful side effects, including death, diabetes mellitus, heart abnormalities, and permanent neurological damage. Holloway Tr. 2495:20-2498:3. Psychotropic medications are "notorious" for their side effects. Holloway Tr. 2537:17-2538:3. Defendants' consultant Dr. Kastner acknowledged that "all psychotropic medications are harmful." Kastner Tr. 4543:11-16. Further, psychotropic medications pose significantly heightened risks for individuals with developmental disabilities. Dr. Eldon Schulz, medical director for the Arkansas Division of Developmental Disabilities, testified that, while the typical child with ADHD may have intolerable side effects in about a range of 3 to 5 percent, an individual with an intellectual status below an IQ of 70 will experience a rate of side effects that goes up to 30 percent, a 10-fold increase. Schulz Tr. 6191:20-6192:3.

507. CHDC staff fail to identify even the most prevalent side effects from medications. The inability of CHDC's staff to assess such side effects is an obvious deficiency in care. Mikkelsen Tr. 3679:5-9.

508. CHDC's failure to detect side effects or toxic levels of medications has harmed CHDC residents. Mikkelsen Tr. 3659:5-8. In particular, CHDC residents, such as CJ, have died, and others, such as CHL, have nearly died, because of CHDC's failure to properly monitor and respond to psychotropic medication side effects. Numerous other CHDC residents are experiencing significant side effects of these medications that CHDC either fails to detect or misdiagnoses and improperly addresses. *See* FOF ## 509-512, 524-527.

509. For example, CHDC gave Resident CJ the psychotropic medication Haldol for the express purpose of suppressing agitation she was experiencing as a result of a seizure medication, Keppra. No evidence showed that, before administering the Haldol to CJ, CHDC made any effort to change or reduce her seizure medications, even though numerous medications can effectively control seizures without causing agitation. Further, CJ did not even have a definitive diagnosis of seizures. As a result of CHDC's prescription of Haldol to CJ, she contracted a preventable disorder, neuroleptic malignant syndrome, which CHDC did not detect, and caused CJ to die. Appx. at 2-5.

510. CHL, a small boy, developed lithium toxicity from medications that CHDC administered to him. His level of lithium toxicity was so high at one point that laboratory equipment could not measure it. CHDC did not detect CHL's lithium toxicity until he was staggering and nearly comatose, although he was showing signs of toxicity weeks earlier. Even when CHL was staggering and nearly comatose, and CHL's lithium level was immeasurably high, CHDC waited

a day to hospitalize him. CHL ultimately had to be airlifted to Arkansas Children's Hospital and subjected to multiple rounds of dialysis to treat the toxic levels of lithium in his body. Appx. at 5-8. Even Defendants' consultant, Dr. Kraus, testified that he would have immediately hospitalized CHL upon receipt of the high lithium reading and that he had unanswered questions about CHL's care. Kraus Tr. 6386:15-18.

511. CHDC has not undertaken any measures to prevent similar episodes of medication overdoses since CHL was hospitalized for lithium toxicity. Mikkelsen Tr. 3681:14-17.

512. Nor does CHL represent an isolated incident. Since CHL had to be hospitalized for lithium toxicity, another CHDC resident, BH, was hospitalized with lithium toxicity. Mikkelsen Tr. 3681:18-3682:15. According to CHDC records, five CHDC residents have been diagnosed with lithium toxicity. Mikkelsen Tr. 3688:21-3689:13; US Ex. 587.

513. Having individuals reach this level of lithium toxicity is extremely rare. Defendants' consultant, Dr. Kraus, admitted that he could not recall any individual whom he had treated in his practice at Rush University Medical Center in Chicago who required hospitalization because of lithium toxicity. Kraus Tr. 6341:22-6342:1.

514. Similarly, Dr. Kraus, admitted he was unaware of any instance in the past two years among his fellow practitioners in Chicago, all of whom commonly prescribe lithium, of an individual requiring hospitalization from lithium toxicity. Kraus Tr. 6342:2-15. Dr. Kraus testified that he is commonly notified of adverse drug reactions like lithium toxicity occurring in the Chicago area and likely would have been notified if a hospitalization from lithium toxicity occurred there. Kraus Tr. 6342:9-12.

515. Because of CHDC's substandard medication practices, numerous other CHDC residents are experiencing significant side effects of psychotropic medications. Holloway Tr. 2601:14-17. For example, records for ACJ indicate that she is experiencing behaviors consistent with medication side effects. Dr. Holloway summarized these as "[a]ppearing overly sleepy, unresponsive, lethargic, confused and disoriented, appearing unusually unsteady and shaky, possible accident, minor injury, falling," and "swelling on her face, inability to void." Holloway Tr. 2602:3-13; US Ex. 877-2.

516. Psychotropic medications cause abnormal motor movements. Holloway Tr. 2497:25-2498:1. Consequently, generally accepted minimum professional standards require CHDC to monitor side effects with objective measures normed to its population. Holloway Tr. 2498:3-8. These include monitoring for akathesia, which is motor restlessness that psychotropic agents can contribute to, and causes significant distress. Holloway Tr. 2498:16-24.

517. CHDC is not adequately identifying individuals with tardive dyskinesia. Holloway Tr. 2607:17-20. Tardive dyskinesia is a psychotropic medication side effect involving abnormal motor movements. Tardive dyskinesia can cause swallowing difficulties, and can affect the limbs and feet. Holloway Tr. 2602:25-2603:4. Variants of tardive dyskinesia include akathesia and tardive dystonia, which is a tightening and twisting of muscle groups. Holloway Tr. 2603:4-8. Tardive dyskinesia, including these and other subtypes, is usually an irreversible condition. Holloway Tr. 2603:12-13.

518. Certain classes of psychotropic medication typically cause tardive dyskinesia. Holloway Tr. 2603:16-21. Studies indicate that approximately 17 to 25 percent of persons exposed to long-term use of psychotropic medications develop tardive dyskinesia. Holloway Tr. 2603:22-2604:5.

519. CHDC has exposed multiple CHDC residents to numerous years of psychotropic medications, especially to first-generation antipsychotics. Holloway Tr. 2604:6-20.

520. Reglan, which is used to treat gastrointestinal disturbance, can contribute to tardive dyskinesia. Holloway Tr. 2605:2-5. CHDC prescribes Reglan to approximately 51 CHDC residents. Holloway Tr. 2605:7-10.

521. Extrapyramidal symptoms (i.e., long-term abnormal motor movements, Holloway Tr. 2593:4-13) are associated with a disorder of the central nervous system and manifest themselves in different ways, including abnormal oral movements, jaw movements, upper extremity movements, drooling, gait change, and finger movements resembling pill rolling. Holloway Tr. 2605:22-2606:14.

522. CHDC limits its medication side effect monitoring to the use of the Abnormal Involuntary Movement Scale ("AIMS"). Holloway Tr. 2595:13-15, 2600:12-14; Mikkelsen Tr. 3657:8-20. The AIMS only identifies dyskinesia (i.e., medication-induced involuntary motor movement). Holloway Tr. 2601:2, 2497:24-2498:3. The AIMS does not capture other serious side effects, such as akathisia or tremors. Holloway Tr. 2595:16-19, 2601:2-4; Mikkelsen Tr. 3657:23-3658:7. Other instruments, such as the MOSES, provide a more comprehensive assessment of side effects. Mikkelsen Tr. 3658:13-19. The AIMS, by itself, is not adequate to assess the side effects of psychotropic medications. Holloway Tr. 2600:21-24.

523. CHDC has identified only eight residents as having either tardive dyskinesia or extrapyramidal symptoms. Holloway Tr. 2605:11-2606:17; US Ex. 874. This list undercounts the number of CHDC residents with a history of tardive dyskinesia or extrapyramidal symptoms. Eight residents is low compared to national statistics regarding rates of tardive dyskinesia or

other extrapyramidal symptoms among individuals who have experienced long-term exposure to psychotropic medications. National statistics indicate that at least 25 percent of such individuals experience such symptoms. Holloway Tr. 2606:18-2607:7. Further, CHDC residents manifesting signs and symptoms of tardive dyskinesia and extrapyramidal symptoms were not included on CHDC's list of individuals experiencing tardive dyskinesia or extrapyramidal symptoms. Holloway Tr. 2607:7-16.

524. Even when CHDC staff do identify potential medication side effects, they fail to follow-up. For instance, CHDC resident BH's psychiatric consultation in May 2009 notes that, according to an AIMS screen, BH has experienced "some involuntary movements with regard to both arms and facial muscles and lip/perioral area. He engages in fairly frequent stereotypical movements of his arms." Holloway Tr. 2607:21-2608:24. These movements are consistent with extrapyramidal symptoms. Holloway Tr. 2609:10-13. Yet, CHDC has not identified BH as having extrapyramidal symptoms. US Ex. 874. After noting that BH is exhibiting possible extrapyramidal symptoms, CHDC's consulting psychiatrist did not advise BH's treatment team to monitor for these movements. Holloway Tr. 2609:17-24. CHDC's consulting psychiatrist also did not explore whether BH's agitation and aggression result from akathesia, which is an extrapyramidal symptom. Holloway Tr. 2609:19-23, 2613:24-2614:3.

525. CHDC's consulting psychiatrist regularly raises medication dosages even while noting the presence of associated side effects. Holloway Tr. 2587:12-19. For instance, although CHDC's consulting psychiatrist noted in May 2009 that BH was experiencing symptoms that are consistent with extrapyramidal symptoms, in July 2009, the psychiatrist concluded that BH was having "no known side effects" from his medications. Holloway Tr. 2607:21-2608:24, 2612:14-

16; US Ex. 880-2. CHDC's consulting psychiatrist made no apparent effort to account for the fact that psychotropic medications prescribed for BH have irreversible side effects and can also suppress symptoms of any side effects. Holloway Tr. 2612:17-2613:10. Instead, he raised the level of BH's medication. Holloway Tr. 2613:11-16.

526. CHDC increased BH's psychotropic medications in response to the frequency of BH's behavior reports. Holloway Tr. 2613:17-20. This is especially concerning, because BH has a history of neuroleptic malignant syndrome. Neuroleptic malignant syndrome can cause death, and is caused by the neuroleptic medication that CHDC was administering to BH. Holloway Tr. 2613:17-20. CHDC increased BH's psychotropic medications without regard to the potential side effects in contrast to generally accepted professional standards. Holloway Tr. 2613:21-23.

527. The consulting psychiatrist's consultation notes of July 2, 2009 for CHDC resident AMB indicate that AMB had "small areas on her forehead, chin, and right side of her face, that she's probably engaged in some skin-picking behavior. She had some infrequent tic-type movements of her eyebrows." Yet, again, the consulting psychiatrist did not carefully assess the possibility of medication side effects. Instead, the consulting psychiatrist's note uses largely the same generic language found in other resident examples - AMB is "having no known current side effects from her psychotropic medication, with the possible exception of some intermittently present abnormal facial movements noted on her AIMS from 2/14/09." Holloway Tr. 2616:3-19; US Ex. 882. Although CHDC's consulting psychiatrist documented the results from CHDC's AIMS screening in his own notes, CHDC failed to identify AMB as having tardive dyskinesia or extrapyramidal symptoms. Holloway Tr. 2616:24-2617:3; US Ex. 874. CHDC's March 10, 2009 problem list for AMB identifies several medical issues consistent with medication side

effects, such as duodenal ulcers, constipation, hyperlipidemia, hypothyroidism, esophagitis, gastritis, silent aspiration, and cataracts. Holloway Tr. 2617:4-25; US Ex. 883. Yet, AMB's record contains no indications that CHDC staff assessed any of these conditions as possible medication side effects. Holloway Tr. 2618:1-15.

528. CHDC's consulting psychiatrist admitted that he typically does not even identify the side effects of the treatments he proposes. Callahan Tr. 5371:22-5372:12. Even in the rare instances where CHDC's psychiatrist does identify possible side effects, he does not communicate them adequately to other treating staff, denying them of information they need to monitor and address the side effects. A psychiatrist must educate staff about what particular side effects to look for, monitor residents whom he is treating, and instruct staff on how to address such side effects. Holloway Tr. 2523:23-2524:24. But at CHDC, the consulting psychiatrist does not take these steps necessary to ensure residents' safety. Mikkelsen Tr. 3625:7-9.

529. Similarly, CHDC's consulting psychiatrist does not complete Adverse Drug Reaction reports or otherwise notify the CHDC Pharmacy and Therapeutics Committee or other entities of potential adverse drug reactions or medication side effects experienced by the residents for whom he provides psychiatric services. Holloway Tr. 2523:14-22, 2587:20-2588:5.

530. The consulting psychiatrist is not a member of the Pharmacy and Therapeutics Committee or on any committee in regards to monitoring medications, or in any way involved in medication monitoring. Holloway Tr. 2590:19-2591:11. The consulting psychiatrist is not aware of the content of CHDC's medication monitoring protocols or even where the protocols are located. Holloway Tr. 2591:12-22; Mikkelsen Tr. 3649:21-3650:2.

531. CHDC does not have a facility-wide system of detecting, reporting, and responding to harmful medication side effects. Holloway Tr. 2592:4-13, 2595:9-12, 2600:15-17; Mikkelsen Tr. 3658:20-25. CHDC does not have a systemic approach for tracking and trending harmful outcomes that result from medication side effects. Holloway Tr. 2600:18-20.

532. CHDC's medical director knows little about CHDC's medication side effect control system. She admitted that she: (1) has no personal knowledge of training provided to staff on medication side effects apart from what staff are told in interdisciplinary team meetings; (2) does not know how many CHDC residents have been identified as having side effects of psychotropic medications; (3) does not know whether CHDC maintains a list of CHDC residents who have been identified as having side effects of psychotropic medications for referral by CHDC staff; and (4) she did not know how or whether CHDC identified trends and side effects experienced by CHDC residents. Thomas Tr. 1737:19-1738:6, 1735:14-19, 1739:2-8, 1743:13-25.

533. CHDC does not adequately train direct care staff to recognize psychiatric side effects. Mikkelsen Tr. 3655:2-8. Staff did not begin receiving detailed training on medication side effects until April 2010. Murphy Tr. 509:10-510:9, 511:22-512:10. CHDC uses lists of potential side effects, but these lists are generic pro forma printouts that are not tailored to the individual receiving the particular medication. Mikkelsen Tr. 3625:23-3626:7. As such, they are clinically deficient. They do not identify pertinent side effects that can be indications of life-threatening conditions, including extrapyramidal muscular movements, orthostatic hypertension, tachycardia, and temperature changes. Holloway Tr. 2592:14:-2594:18; US Ex. 898 at CON-US-0127243. They do not identify the likelihood of one particular side effect versus another.

Mikkelsen Tr. 3626:8-12. They have little utility in informing treatment team members about what to watch for. Mikkelsen Tr. 3626:13-16.

534. Defendants' consultant, Dr. Kraus, agreed that the side effect sheets distributed at interdisciplinary meetings are generic printouts from CHDC's pharmacy that do not educate staff as to which side effects are of particular concern. Kraus Tr. 6334:9-6335:6. Dr. Kraus also confirmed that CHDC's consulting psychiatrist does not actually attend interdisciplinary team meetings. Kraus Tr. 6335:7-12.

C. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Clinically Deficient Diagnoses That Are Used To Justify the Administration of Psychotropic Medications.

535. CHDC's consulting psychiatrist uses clinically unsupported diagnoses to justify the unwarranted use of psychotropic medications that needlessly expose CHDC residents to harmful side effects and often worsen the very behaviors the medications are used to suppress. In particular, CHDC: (1) does not eliminate potential non-psychiatric causes of challenging behaviors before assigning psychiatric diagnoses to its residents; (2) improperly relies on broad categories of behavior, such as aggression, to justify psychiatric diagnoses; and (3) saddles its residents with unsubstantiated, clinically unjustified, and even clinically illegitimate psychiatric diagnoses. *See* FOF ## 536-554.

536. All relevant witnesses agreed that, prior to prescribing psychotropic medications, generally accepted practice requires CHDC first to exclude non-psychiatric causes of the individual's symptoms, such as general medical problems, learned behaviors, and environmental conditions. *See* Mikkelsen Tr. 3586:12-16; Kraus Tr. 6234:22-6235:1 (Defendants' consultant);

Schulz Tr. 6190:14-6191:15 (medical director for the Arkansas Division of Developmental Disabilities).

537. Regardless of the level of an individual's disability, it is clinically unacceptable to use psychotropic medications in response to an individual's behaviors without having ruled out environmental or situational causes, and absent indicia of an underlying psychiatric disorder. Mikkelsen Tr. 3599:15-3606:9.

538. A major reason for this rule-out approach is that large numbers of individuals with developmental disabilities have medical or other problems that precipitate behavioral presentations that can be misdiagnosed as psychiatric disorders. Mikkelsen Tr. 3586:17-22. As Defendants' consultant Dr. Kastner testified, "I think Dr. Mikkelsen and I would agree that in general you don't want to use psychotropic medication to treat specifically behavioral symptoms. It happens a lot. It's not something that I would encourage." Kastner Tr. 4141:7-11

539. Once non-psychiatric factors are ruled out, the psychiatrist should begin to form a hypothesis about a psychiatric disorder. In doing so, the psychiatrist should determine whether specific symptoms can explain the disorder. Mikkelsen Tr. 3587:4-9. To reach such a diagnosis, a psychiatrist should identify specific indicia of psychiatric distress. Mikkelsen Tr. 3593:10-17. This requires informing direct care staff of what specific symptoms to track and report. Mikkelsen Tr. 3593:18-22.

540. Yet, Dr. Callahan, the CHDC consultant psychiatrist who sees virtually every CHDC resident receiving psychiatric treatment, Callahan Tr. 5333:14-23, admitted that he plays *no* role in accounting for non-psychiatric factors before diagnosing individuals with a psychiatric disorder. *See* Mikkelsen Tr. 3596:12-17. Dr. Mikkelsen's review of almost 80 charts confirmed

that Dr. Callahan failed to account for non-psychiatric factors. Mikkelsen Tr. 3596:17-3597:11. Moreover, CHDC's consultant psychiatrist admitted that he does not even determine the symptoms of an individual's purported psychiatric illness. Callahan Tr. 5365:13-15. Rather, he simply relies on what psychology examiners tell him the symptoms are, without any input or guidance from him. Holloway Tr. 2529:22-2530:25, 2531:1-13; Mikkelsen Tr. 3596:7-16, 3598:4-8.

541. Further, the information provided by CHDC psychology examiners typically consists of unhelpful raw behavioral data that has not been filtered by any diagnostic criteria. Mikkelsen Tr. 3598:4-14. CHDC's consulting psychiatrist admitted that typically the information he reviews regarding an individual's status consists only of broad categories of maladaptive behaviors reflected in rates of aggression and frequency of time in restraints. Callahan Tr. 5366:12-5368:8; US Ex. 824 at CON-US-0126032. Yet, even the "Experts' Consensus Guidelines" that the Defendants invoke as a standard require the delineation of "specific index behaviors." Kraus Tr. 6317:7-6318:10. Data on the frequency of self-injurious behavior, aggression, or restraint use, is itself an insufficient basis for reaching a clinically adequate psychiatric diagnosis. Mikkelsen Tr. 3592:5-9. Such data is too broad and must be refined in order to be linked to, and justify, a particular diagnosis. Mikkelsen Tr. 3592:10-3594:8. CHDC's information deficiency makes it "virtually impossible" for a psychiatrist to reach a professional psychiatric diagnosis. Mikkelsen Tr. 3597:16-3598:3, 3598:9-14.

542. CHDC's consulting psychiatrist admitted that aggression, by itself, is a nonspecific behavior. Callahan Tr. 5368:10-12. Similarly, Defendants' consultant Dr. Kraus testified that aggression can have many causes. Kraus Tr. 6317:4-6. Without a direct link to symptoms

characteristic of a psychiatric disorder, aggression is too nonspecific a behavior for CHDC to use for assessments and treatment. Mikkelsen Tr. 3587:4-3588:4.

543. To make a professional psychiatric diagnosis and assess the efficacy of treatment, the psychiatrist must also instruct the individual's interdisciplinary team as to what data to report back to the psychiatrist regarding the individual and his or her symptoms. Holloway Tr. 2490:23-2491:14, 2520:23-2521:17, 2523:4-8; Mikkelsen Tr. 3596:1-11. Conversely at CHDC, the consulting psychiatrist admitted, and individuals' charts confirmed, that he simply defers to the unqualified psychology examiners as to what information should be tracked. Mikkelsen Tr. 3596:7-3597:2; *see* FOF # 540.

544. Moreover, contrary to generally accepted professional standards, CHDC's consulting psychiatrist does not memorialize an explanation as to how identified maladaptive behaviors are manifestations of the psychiatric diagnosis assigned to an individual. He explained that he keeps that information in his head. Mikkelsen Tr. 3608:17-23. This is a clinically deficient practice that does not comport with generally accepted practice. Mikkelsen Tr. 3608:24-3609:2. This "in his head" explanation also exacerbates CHDC's problem with internally inconsistent medical charts documenting residents' psychiatric diagnoses. Holloway Tr. 2535:9-21.

545. In addition, psychiatric diagnoses at CHDC contradict other aspects of the individual's presentation. Mikkelsen Tr. 3609:3-3610:4. This is evident in the records of CHDC's residents. Examples include CHDC diagnosing persons with profound or severe intellectual disabilities as also having attention deficit disorder despite the fact that their level of attention is essentially not measurable. Mikkelsen Tr. 3738:15-18. Other examples include diagnoses of personality change associated with congenital conditions occurring while an infant is still in utero, such as

personality change due to cerebral palsy. Mikkelsen Tr. 3609:13-22, 3610:22-3611:3, 3612:2-10. Similarly, CHDC diagnosed ACJ with "organic mood disorder," an unrecognized and nonexistent diagnosis in the field of psychiatry. Holloway Tr. 2582:11-18.

546. CHDC's consulting psychiatrist's diagnoses are also inappropriate because he makes diagnoses for reasons based on illegitimate, non-diagnostic criteria. In particular, CHDC's consulting psychiatrist admitted that he essentially gives a psychiatric diagnosis to most individuals referred to him at CHDC, even though he admitted that "the primary care physician might well write a referral [to him] just based on" an individual being "aggressive or self-injurious" when the individual is medically assessed upon admission." Callahan Tr. 5370:12-5371:10.

547. Even Defendants' consultant Dr. Kraus recognized the consulting psychiatrist's conflicting and clinically unsound diagnoses and raised concerns about the substandard practice with Dr. Callahan. Dr. Kraus testified, "I spoke with Dr. Callahan about a number of the descriptions of personality change with some type of organic etiology like fetal -- personality change related to fetal alcohol syndrome or personality change related to microcephaly, for example." Kraus Tr. 6257:24-6258:3. "It's not -- this is not -- I did talk to him. This is not a DSM-IV description. You don't have personality change from fetal alcohol syndrome." Kraus Tr. 6258:24-6259:1.

548. CHDC also makes unjustified diagnoses that fail to account for behaviors that are common in individuals with developmental disabilities or in individuals with autism. For instance, persons with severe and possibly profound intellectual disabilities may engage in obsessive behaviors simply as a coping mechanism. Mikkelsen Tr. 3613:6-9. Also, persons with

autism disorder have inherent obsessive symptoms. Mikkelsen Tr. 3612:19-23. Further, Defendants' witness, Dr. Parmley, testified that a diagnosis of autism precludes some other diagnoses, including attention deficit hyperactivity disorder and possibly obsessive compulsive disorder ("OCD"). Parmley Tr. 5473:18-25. Accordingly, in diagnosing OCD for an individual with developmental disabilities, a clinician must determine that obsessive behaviors are distinct from autism-related behaviors or other behaviors attributable to an individual's developmental disability. Mikkelsen Tr. 3612:23-3613:1.

549. Yet, as further evidence of these unjustifiable diagnoses, 27 percent of CHDC residents with a psychiatric diagnosis were also diagnosed as having OCD. Mikkelsen Tr. 3612:14-16. This 27 percent is high compared to the general landscape of persons with developmental disabilities who have a psychiatric disorder. Mikkelsen Tr. 3614:14-20. This rate is also presumptively invalid, given the psychiatric assessments required to make it, Mikkelsen Tr. 3612:17-3613:1, and especially given that CHDC's consulting psychiatrist admits that he does not rule out non-psychiatric causes before rendering a diagnoses. Mikkelsen Tr. 3596:7-17.

550. Diagnoses matter because they determine treatments used. Mikkelsen Tr. 3588:16-3589:6, 3610:10-13, 3615:19-3616:1; Holloway Tr. 2535:24-2536:7. CHDC's deficient psychiatric diagnoses cause harmful treatment implications for CHDC residents. For instance, although CHDC diagnoses many residents with both bipolar and anxiety disorders, common treatments for anxiety disorder will often disrupt a person with bipolar disorder. Mikkelsen Tr. 3611:5-3612:1.

551. A recognized treatment for obsessive compulsive disorder is the use of a class of medications called "SSRIs." These medications can cause a paradoxical reaction of

disinhibition, or excitement, if someone actually has autism, and have the potential to destabilize the individual. Mikkelsen Tr. 3613:24-3614:13. CHDC's consulting psychiatrist acknowledged that, in general, SSRIs have been less effective in treating persons whom he has diagnosed with OCD. Mikkelsen Tr. 3614:24-3615:5. This implies that CHDC wrongly diagnosed these residents with OCD. Mikkelsen Tr. 3615:6-8. The high rate of persons diagnosed with OCD and the lack of efficacy at CHDC of the standard treatment for this disorder are further evidence of CHDC's deficiencies in diagnosing psychiatric disorders.

552. TN's case illustrates these CHDC deficiencies. CHDC's consulting psychiatrist first diagnosed TN with attention deficit disorder, hyperactivity type, notwithstanding that TN was also diagnosed as having a profound intellectual disability. Persons having profound intellectual disabilities have impaired attention, making such an attention deficit disorder diagnosis difficult to establish. Mikkelsen Tr. 3738:11-18. Further, administering antidepressants to someone who has a bipolar disorder risks precipitating a manic episode. Mikkelsen Tr. 3740:3-6. Yet, CHDC's consulting psychiatrist subjected TN to two trials of antidepressants. Mikkelsen Tr. 3739:6-3740:2. Both trials triggered manic episodes in TN. Mikkelsen Tr. 3739:6-3740:2. CHDC's consulting psychiatrist subjected TN to the second trial of antidepressants even after the first trial made TN manic and after he diagnosed TN with bipolar disorder, a condition well known to trigger a manic reaction to antidepressants. Mikkelsen Tr. 3739:8-3740:2; Appx. at 9-10.

553. Similarly, regarding an adolescent male, TM, the CHDC psychiatric consultant noted when first seeing TM that "all the aggression seemed to be a response to something going on around him as opposed to a strictly internal process." US Ex. 875 at CON-US-0274721-723;

Holloway Tr. 2549:1-7. Thereafter, the consulting psychiatrist assigned TM the psychiatric diagnoses of both psychosis and generalized anxiety disorder. Holloway Tr. 2550:3-2551:2; US Ex. 875 at CON-US-0274719. Yet, simultaneously assigning these diagnoses is clinically unjustifiable. The standard psychiatric diagnostics tool, the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision ("DSM-IV-TR") instructs that these diagnoses are incompatible and cannot be appropriately assigned simultaneously to the same person. Holloway Tr. 2550:14-23. Additionally, the treatments for psychosis and generalized anxiety disorder are incompatible. Holloway Tr. 2551:3-5. Separately, the consulting psychiatrist did not provide any guidance to TM's treatment team regarding what to track in order to establish or rule out his diagnosis. Holloway Tr. 2551:15-2553:9.

554. TM also illustrates clinically deficient diagnoses that were noted by Defendants' consultant Dr. Kraus. CHDC's consulting psychiatrist unjustifiably diagnosed TM with personality change due to microcephaly. Holloway Tr. 2693:15-2694:5, US Ex. 875. Microcephaly is typically a congenital condition resulting in a small brain at birth. Absent establishing that TM was experiencing ongoing shrinkage of the brain, which was not established for TM, microcephaly could not ever justify a clinical diagnosis of personality change. Holloway Tr. 2721:9-2722:9; Kraus Tr. 6257:24-6258:3, 6258:24-6259:1.

D. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Harmful Medication Practices.

555. CHDC administers medications to its residents that are not justified by their diagnoses. Further, as with other deficiencies in psychiatric care, CHDC allows non-clinicians to control decisions regarding medication usage. CHDC engages in this practice in part so that it can

administer psychotropic medications to its residents to suppress behaviors and for other clinically unjustified reasons. *See* FOF ## 556-581.

1) CHDC's Clinically Unjustified Selection of Medication

556. Once a psychiatric diagnosis is reached, the psychiatrist should select from among those treatments that are evidence-based, meaning treatments that have been clinically substantiated through research studies and published literature to have demonstrated efficacy and fit for particular psychiatric diagnoses. In making this selection, the psychiatrist should weigh the potential side effects and likely efficacy of the treatment against the harms associated with the diagnosed condition. Mikkelsen Tr. 3588:16-3589:6, 3615:19-3616:1.

557. The CHDC consulting psychiatrist's notes should clearly articulate the risks and benefits of the chosen treatment, the hypothesis of why he is selecting particular medications, and what symptoms he is targeting. Holloway Tr. 2525:11-23. His notes need to show that his treatment decisions are based on clinical information, and he should amalgamate all this relevant information so that clinicians involved in the individual's care can readily determine why the psychiatrist is using the medication. Holloway Tr. 2525:11-23, 2568:2-13, 2568:25-2569:9.

558. In comparison, CHDC's consulting psychiatrist admitted that he does not set out the risks and benefits of medications in his note. Further, he does not educate the team about the risks and benefits of medications, nor does he participate in team discussions of risks and benefits of medications. Callahan Tr. 5371:13-5373:12. Finally, he does not amalgamate all relevant information so that clinicians involved in the individual's care can access it. Holloway Tr. 2535:9-21 (noting internally inconsistent documentation of residents' psychiatric diagnoses).

559. Further, CHDC does not assess in any confirmable way whether the side effects of those medications outweigh the risks associated with the diagnosed psychiatric condition. Even worse, in response to guardians' wishes, CHDC engages in a pattern of administering medications to its residents that its consulting psychiatrist believes are unwarranted and possibly harmful. Mikkelsen Tr. 3616:21-3618:20. CHDC's consulting psychiatrist has acknowledged engaging in this practice in his psychiatric notes. Mikkelsen Tr. 3619:22-3620:6.

560. Repeated examples confirm that CHDC does not select medications based on any finding that the medications have been clinically shown to fit a resident's particular diagnosis and that they have a demonstrated efficacy for that diagnosis. CHDC engages in a pattern of prescribing medications to its residents that are not aligned with the psychiatric diagnoses assigned to those residents. Mikkelsen Tr. 3616:8-20.

561. These practices constitute an illegitimate use of psychotropic medication, and substantially depart from generally accepted minimum professional standards. Mikkelsen Tr. 3616:2-3617:7, 3618:15-20.

562. As Dr. Mikkelsen testified, there are "fundamental problems" in that CHDC's consulting psychiatrist believes that non-clinicians control medications and dosages to such a degree that the psychiatrist sees himself as having to make unethical treatment decisions regarding CHDC residents. Mikkelsen Tr. 3769:9-16.

563. CHDC's treatment of SS illustrates this deficiency of prescribing medications determined to be unhelpful or even harmful. Throughout most of the 1990s, SS had experienced great stability on the medication Mellaril. Mikkelsen Tr. 3758:25-3759:2. CHDC's consulting psychiatrist switched SS from Mellaril to Zyprexa because of SS's guardian's wishes, even

though the consulting psychiatrist concluded that the Zyprexa caused SS to experience glucose problems associated with diabetes mellitus and that there had not been in a major change in SS's overall condition on the Mellaril. Mikkelsen Tr. 3759:18-3760:3. In fact, CHDC's data indicate that SS's acts of aggression had decreased by 80 percent while she was receiving the Mellaril, as compared with when she was receiving Zyprexa. Mikkelsen Tr. 3760:12-21. CHDC subjected SS to dangerous medication side effects, against the treating professional's judgment, due to SS's guardian's wishes, even though the original medication was more effective in treating SS's behavior. Mikkelsen Tr. 3757:2-15; US Ex. 816.

564. Separately, CHDC's consulting psychiatrist has treated residents with medications that are known to be harmful, without any clinical justification for the risk of harm. For example, the consulting psychiatrist recommended administering an anti-anxiety medication, lorazepam (also known as Ativan) to CHDC resident BH for behavior suspected to result from a change in BH's assigned staff. Holloway Tr. 2610:24-2611:5. Independent of the inappropriate use of a psychotropic medication to address environmental factors, Holloway Tr. 2611:6-9, lorazepam is not advised for someone with developmental disabilities unless absolutely necessary because it affects cognitive functioning. Holloway Tr. 2611:12-19. In addition, lorazepam is highly addictive. Holloway Tr. 2612:1-4. Professional standards require a risk/benefit analysis before CHDC used this medication with an individual with developmental disabilities. Holloway Tr. 2611:17-24. BH's record, however, shows no evidence that CHDC's consulting psychiatrist undertook such risk/benefit analysis. Holloway Tr. 2614:8-13.

565. In addition, Defendants' own witnesses admit that CHDC treats children with autism with psychotropic medications that have been clinically shown to be ineffective and harmful to

children. Kraus Tr. 6296:14-6300:4. Defendants' consultant Dr. Kraus testified that Dr. Fred Volkmar is the preeminent expert on autism in the country, if not the world. Kraus Tr. 6371:7-12 ("I would believe anything Dr. Volkmar had to say regarding autism and the treatment related to autism."). In an article Defendants cited at trial, Dr. Volkmar stated that a medication used at CHDC on children with autism, citalopram, "exhibited significant adverse effects without any evident therapeutic effects in children." Kraus Tr. 6383:2-4.

2) Clinically Unjustified Medication Usage

566. CHDC's consulting psychiatrist's notes make clear that he improperly uses psychotropic medications for reasons unrelated to a psychiatric disorder. Mikkelsen Tr. 3620:13-16. For example, CHDC's consulting psychiatrist uses psychotropic medications to suppress the effects of other medications, in response to environmental factors, and as chemical restraints. *See* FOF ## 567-581.

i. CHDC Improperly Uses Medications To Suppress the Effects of Other Medications.

567. CHDC's consulting psychiatrist encourages the use at CHDC of psychotropic medications to suppress the side effects of another medication without first attempting to remove or replace the offending medication. This practice pattern is an illegitimate use of psychotropic medication, and substantially departs from generally accepted minimum standards. Mikkelsen Tr. 3616:21-24, 3617:7-23, 3618:15-20, 3644:22-3645:13.

568. CHDC's consulting psychiatrist has openly advocated the use of the psychotropic medication Haldol to suppress agitation caused by another medication, Keppra, without first

attempting to remove or replace the offending medication. Mikkelsen Tr. 3643:12-3644:6; US Ex. 767; Appx. at 2-3.

569. Beyond advocating this practice, CHDC's consulting psychiatrist actually has treated a CHDC resident with Haldol to suppress agitation suspected to be caused by Keppra, without first attempting to remove or replace the Keppra. Mikkelsen Tr. 3644:8-16. Haldol can cause a potentially fatal disorder called neuroleptic malignant syndrome. As explained above, CHDC's use of Haldol on CHDC resident CJ caused CJ to contract neuroleptic malignant syndrome and die. Mikkelsen Tr. 3644:8-18; Appx. at 2-5; *see* FOF # 509.

ii. CHDC Improperly Uses Medications in Response to Environmental Factors.

570. Psychotropic medications should not be used to treat environmentally driven situations. Holloway Tr. 2538:2-3; *see* FOF ## 536-537. CHDC's consulting psychiatrist, however, prescribes psychiatric medications, and recommends dosage increases, for causes that he expressly acknowledges are environmental. Mikkelsen Tr. 3620:7-12; Holloway Tr. 2529:6-8.

571. CHDC's charts routinely identify environmental factors, such as a change in staff persons or a loud roommate, as the cause of a person's change in behaviors. These charts note CHDC's clinically deficient response of administering psychotropic medications to treat the environmentally caused change. Holloway Tr. 2536:17-2537:11; Mikkelsen Tr. 3768:11-15.

572. As noted above, CHDC's consulting psychiatrist improperly recommended that CHDC administer lorazepam, an addictive anti-anxiety medication that affects cognition, to resident BH because of BH's environmental response to a change in staff. *See* FOF # 564; Holloway Tr.

2610:24-2611:5. This is another example illustrating CHDC's inappropriate use of psychotropic medication to address behaviors caused by environmental factors. Holloway Tr. 2611:6-9.

573. CHDC's consulting psychiatrist treats environmentally caused behavior problems with psychotropic medications because CHDC does not address these problems behaviorally or environmentally. Mikkelsen Tr. 3768:16-25, 3769:5-9.

iii. CHDC Improperly Uses Medications for Chemical Restraint.

574. CHDC subjects hundreds of residents to mind-altering psychotropic medications to suppress maladaptive behaviors without a psychiatrist first ruling out non-psychiatric causes of the behaviors. These non-psychiatric causes include possible physical health issues, means of coping (i.e. "learned behaviors"), and environmental factors. Most commonly, CHDC gives psychotropic medications to control so-called "aggressive" or "self-injurious" behaviors. This wide-spread practice constitutes professionally prohibited, chemical restraint. *See* FOF ## 575-581.

575. CHDC uses psychotropic medication on its residents predominately for maladaptive behavior unassociated with a clinical diagnosis of mental illness. Holloway Tr. 2534:21-2535:3, 2533:19-25. A psychiatrist cannot legitimately justify the selection of medication based on aggression by itself. Yet, CHDC's consulting psychiatrist's notes present behavioral data in terms of numbers of incidents of aggression, and he improperly bases his treatment decisions on rates of aggression. Holloway Tr. 2532:3-16.

576. CHDC's consulting psychiatrist admitted that typically the information he reviews regarding an individual's status consists of only generic descriptions of maladaptive behaviors and negative outcomes, such as rates of aggression and frequency of time in restraints. Callahan

Tr. 5366:12-5368:8; US Ex. 824 at CON-US-0126032. Having no other justification, CHDC regularly uses psychotropic medication solely to sedate its residents. This constitutes the illegitimate use of psychotropic medications as chemical restraint. Holloway Tr. 2534:1-18; Mikkelsen Tr. 3616:21-24, 3617:25-3618:1, 3618:15-20. This illegitimate chemical restraint occurs "daily" at CHDC. Mikkelsen Tr. 3618:21-3619:12.

577. CHDC continues to use psychotropic medications as chemical restraints even when Defendants' own clinicians have identified such use as harmful. Dr. Eldon Schulz, medical director of the Arkansas Division of Developmental Disabilities, testified that Depo-Provera has been used to curb hypersexuality in adult males. Schulz Tr. 6187:21-22. Dr. Schulz testified that the State discontinued the use of Depo-Provera in men because the drug posed significant side effects, including breast cancer and testicular cancer. Schulz Tr. 6187:12-6188:5. Defendants' consultant Dr. Kraus testified that Depo-Provera is a form of chemical castration. Kraus Tr. 6257:2-7. Yet, Dr. Kraus also confirmed that CHDC continues to use Depo-Provera on adolescent males. Kraus Tr. 6256:24-6257:20.

578. Other specific examples of CHDC's use of unjustified chemical restraint include resident TC, a young boy admitted to CHDC in August 2007, at the age of 6. Mikkelsen Tr. 3720:4-9; US Ex. 803. TC was diagnosed with autism, but no other psychiatric disorders, at admission to CHDC. Mikkelsen Tr. 3720:15-20. For the next two years, TC's only psychiatric diagnosis continued to be autism. Mikkelsen Tr. 3730:21-24. Yet, in response to "possible situational" factors, CHDC's consulting psychiatrist recommended increasing TC's Thorazine dosage, which CHDC had been administering to TC since his admission there. Mikkelsen Tr. 3733:10-14, 3729:25-3730:5; US Exs. 805 & 806. Thorazine has sedating effects, and no clinical basis exists

for a psychiatrist to use Thorazine to treat autism, particularly for a child. Mikkelsen Tr. 3730:11-3731:5. Tellingly, the consulting psychiatrist did not offer a clinical justification for this use. Mikkelsen Tr. 3731:3-5. Even TC's team admitted that the cause of TC's behavior was not psychiatric. Mikkelsen Tr. 3755:1-4, 3734:17-23. Yet, CHDC administered psychiatric medications for the non-psychiatric purpose of chemically restraining TC. Mikkelsen Tr. 3736:8-11; Appx. at 12-15.

579. In another example of chemical restraint, CHDC's consulting psychiatrist recommended increasing the dosage of the psychotropic medication Seroquel that CHDC administered to DH because DH became agitated when receiving redirection from CHDC staff. Mikkelsen Tr. 3767:2-12; US Ex. 836. CHDC used this increase in psychotropic medication to chemically restrain DH's behavioral difficulties, not treat a psychiatric disorder. Mikkelsen Tr. 3767:13-20.

580. Youth LW represents yet another example of CHDC's unjustified chemical restraint use. LW was admitted to CHDC in 2008 at age 6. Holloway Tr. 2558:19-2559:4; US Ex. 899 at CON-US-0134185. LW's individual program plan does not indicate that LW is receiving any medications for psychiatric reasons, apart from a sleeping disorder. Holloway Tr. 2558:19-2559:18. LW's annual nursing assessment indicates that he is given the medication trazadone for sleep *at noon*. Holloway Tr. 2559:21-2560:2; US Ex. JH-1. Trazadone is an extreme sedative that is inconsistent with normal daily activities for a six-year-old boy, such as school. Holloway Tr. 2560:19-2561:1.

581. LW's nursing assessment also states that trazadone is administered for behavioral reasons. US Ex. JH-1; Holloway Tr. 2561:19-2562:1. CHDC physician Dr. Parmley admitted that LW is administered trazadone in the middle of the day for behaviors. Parmley Tr. 5455:6-

24. Neither LW's nursing assessment nor his individual program plan provides a clinically justifiable purpose for CHDC to give him trazadone for behaviors. US Exs. 899 & JH-1; Holloway Tr. 2562:9-10, 2566:5-13. LW is receiving trazadone as a chemical restraint. Holloway Tr. 2562:7-10.

E. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Clinically Deficient Assessments of Medication Efficacy.

582. Properly tracking pro-social and negative behaviors forms an essential part of determining psychiatric treatment. Appropriate medication and psychiatric diagnosis should cause associated symptoms and behaviors to decrease, while pro-social behaviors should increase. Pro-social behaviors include participating in outings, engaging in appropriate interactions, and other activities that are generally viewed as positive. A clinician cannot appropriately determine treatment efficacy without assessing whether all of an individual's behaviors, positive and negative, have been affected. Mikkelsen Tr. 3598:18-3599:6. Contrary to this standard, CHDC's consulting psychiatrist admitted that typically the information he reviews regarding an individual's status consists only of negative considerations - rates of aggression and frequency of time in restraints. Callahan Tr. 5366:12-5368:8; US Ex. 824 at CON-US-0126032. Relatedly, psychology examiners typically report to the consulting psychiatrist only the frequency of problematic behaviors that have been targeted by behavior plans, such as occurrences of aggression or self-injurious behavior. Mikkelsen Tr. 3626:17-3627:5. They typically do not even mention pro-social behaviors. Mikkelsen Tr. 3627:6-10.

583. Further, generally accepted professional standards require a psychiatrist to link the plan of treatment to established target symptoms associated with an individual's psychiatric diagnosis.

Yet, CHDC's consultant psychiatrist does not explain in his treatment plan how the medications should affect the symptoms of the individual's disorder. Holloway Tr. 2533:16-18. Nor does he otherwise outline the target symptoms that are associated with a specific diagnosis. Holloway Tr. 2532:16-17. He also does not instruct the individual's treatment team what to assess, or how to assess it, to determine whether the medication is actually helping the individual. Mikkelsen Tr. 3624:22-3625:7.

584. Instead, as in many other aspects of psychiatric care at CHDC, the facility makes psychology examiners responsible for establishing the targets to judge a medication's efficacy. Holloway Tr. 2529:22-2530:25, 2531:1-5; Mikkelsen Tr. 3624:22- 3625:2, 3598:4-8; *see also* Callahan Tr. 5365:13-15 (CHDC's psychiatrist admitted this fact at trial.).

585. Closely related to determinations of medication efficacy are a psychiatrist's professional determination of when to increase or lower, *e.g.*, "taper," the psychotropic medications that an individual receives, because both determinations depend on assessing the individual's response to the medication. Taper criteria should be established according to evidence-based practice regarding psychiatric disorders and associated medications, and objective data based on the individual's target symptoms and ability to participate and enjoy daily activities. Holloway Tr. 2579:6-2580:3, 2577:14-2578:3.

586. At CHDC, taper criteria for medications substantially depart from generally accepted minimum standards. As in other areas of psychiatric care, CHDC psychology examiners establish the taper criteria for medication adjustments at CHDC without the consulting psychiatrist's participation. Holloway Tr. 2532:24-2533:2; *see also* Callahan Tr. 5364:2-10

587. Contrary to CHDC's practice, taper criteria should not be based simply on incidents of aggression. Holloway Tr. 2581:3-7. Yet, CHDC psychology examiners use rates of broad behaviors, such as aggression, as the driving force behind assessing medication effects. Holloway Tr. 2533:3-9. Moreover, CHDC's focus is on maladaptive behaviors that are not even linked or identified with a diagnostic condition. Holloway Tr. 2533:19-25. Beyond CHDC's substandard taper practice, this also shows CHDC's improper use of psychotropic medication as chemical restraint to suppress behaviors.

588. The improper taper criteria CHDC employed to reduce LW's psychotropic medication, trazadone, illustrates this deficiency. The criteria require that LW sleep an average of eight hours a night for a year, a standard that would be too high for most individuals to achieve. Holloway Tr. 2561:15-18, 2580:4-15; US Ex. 899 at CON-US-0134 200. The taper criteria found throughout the individual program plans for CHDC residents have similar critical flaws. Holloway Tr. 2580:16-24.

F. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Delayed Psychiatric Assessments.

589. CHDC's failure to provide timely and comprehensive consultations and assessments substantially departs from generally accepted practices. Holloway Tr. 2621:14-18; *see* FOF ## 591-595.

590. For extended periods of time, CHDC routinely withholds psychiatric care from residents whom CHDC has identified as experiencing psychiatric distress or psychiatric instability. This delay in psychiatric intervention is a substantial departure from generally accepted professional standards that exposes individuals to harm and risk of harm from prolonged psychiatric distress

and instability. CHDC compounds this delay in psychiatric services by also failing to provide sufficient amounts of psychiatric services. *See* FOF ## 591-610.

1) CHDC's Substandard Delays in Seeing Individuals After Admission

591. CHDC's consulting psychiatrist does not see individuals identified as having possible psychiatric issues in a clinically appropriate time after admission. Holloway Tr. 2517:13-23; Mikkelsen Tr. 3654:22-3655:1. CHDC's consulting psychiatrist acknowledged that he does not know when he sees individuals following their admission to CHDC. Holloway Tr. 2517:7-12.

592. According to generally accepted professional standards, a qualified child and adolescent psychiatrist should perform a consultation within 7 days of admission for patients age 14 and 15 (and a follow up every 30 days) and within 21 days for patients 16 to 17 (and a follow up every 45 days). US Ex. 870; Holloway Tr. 2548:4-10. Even Defendants' consultant Dr. Kastner identified 30 days of admission as an appropriate care standard for psychiatric evaluations after admission. Kastner Tr. 4085:19-25.

593. As discussed above, CHDC admitted a young boy, CHL, while he was receiving the psychotropic medication lithium. *See* FOF # 510. This medication must be carefully managed because of the narrow range between what is therapeutic and toxic. A child psychiatrist should see a young boy on lithium soon after admission. Mikkelsen Tr. 3681:8-13. In CHL's case, CHDC's consulting psychiatrist did not see CHL or even involve himself in CHL's care until more than five weeks after CHL was admitted to CHDC. *Even more* dangerously harmful, this included *a week after* CHL became comatose from lithium toxicity, had to be airlifted to the hospital, was subjected to multiple rounds of dialysis, and nearly died. US Ex. 897; Appx. at 5-8.

594. Defendants' own witnesses repeatedly confirmed that CHDC routinely and grossly exceeds the clinical standards of care endorsed by Dr. Holloway, and even Defendants' consultant Dr. Kastner. *See* Kraus Tr. 6251:8-25 (CHDC resident MB was admitted to CHDC with a number of medical and psychiatric disorders but was not seen by a psychiatrist until approximately three months after her admission.), 6261:15-6262:17 (CHDC resident HB was admitted to CHDC with a number of complex medical, behavioral, and psychiatric disorders but was not seen by a psychiatrist until approximately two months after his admission.), 6304:21-6305:9 (CHDC resident JM was admitted to CHDC with a number of medical and psychiatric diagnoses, including seizures, autism, and "stable brain atrophy," and while receiving multiple psychotropic medications, but was not seen by a psychiatrist until approximately two months after his admission.), 6269:11-20 (CHDC resident MM was admitted to CHDC with a number of behavioral and psychiatric disorders but was not seen by a psychiatrist until approximately seven weeks after admission.), 6270:22-6271:7 (CHDC resident CJ was admitted to CHDC with a psychiatric diagnosis of autism and was receiving multiple psychotropic medications but was not seen by a psychiatrist until approximately eight weeks after admission.), 6307:6-15 (CHDC resident SW was admitted to CHDC with diagnoses of seizures, autism, and anxiety disorder but was not seen by a psychiatrist until approximately seven weeks after admission.), 6271:8-6272:7 (CHDC resident RD was admitted to CHDC with a number of medical disorders and while receiving multiple psychotropic medications, but was not seen by a psychiatrist until approximately eight weeks after admission.), 6280:2-18 (CHDC resident HA was admitted to CHDC with a history of ADHD but was not seen by a psychiatrist until approximately 12 weeks after admission.); Holloway Tr. 2545:16-2546:16, 2546:22-2547:6; Kraus Tr. 6292:9-20; US Ex. 875 at CON-US-0274721-723 (CHDC resident TM was admitted to CHDC while receiving the

psychotropic medication Risperdal twice a day. TM also had a history of prior psychiatric hospitalizations and a seizure disorder. Nevertheless, TM was not seen by a psychiatrist until approximately five weeks after admission to CHDC.).

595. CHDC's excessive delays in providing psychiatric care to individuals who have been identified with psychiatric needs harms these individuals by leaving them in psychiatric distress and instability and exposes them to harm from improperly managed psychotropic medication, as evidenced by CHL. *See* FOF ## 510, 591 & 592.

2) Clinically Inadequate Psychiatric Oversight

596. According to CHDC, many of its residents have highly complex psychiatric needs. Kraus Tr. 6232:6-15; Mikkelsen Tr. 3584:5-8. In fact, nearly 300 of CHDC's 500 residents receive psychotropic medications, and approximately half of them receive multiple psychotropic medications. Mikkelsen Tr. 3584:16-19.

597. Although CHDC administers psychotropic medications to most of its residents, CHDC fails to provide them with timely psychiatric oversight of those medications, exposing them to harm from inadequate medication management and insufficient psychiatric care to meet their needs. CHDC makes residents with severe psychiatric diagnosis and complex medication regimens wait months for necessary follow up and monitoring. *See* FOF ## 598-609.

598. According to generally accepted professional standards, a psychiatrist should physically see an individual who is not doing well psychiatrically at least once every two weeks to stabilize the individual. Holloway Tr. 2511:16-19. The psychiatrist should conduct follow-up visits at least weekly for an unstable individual who is undergoing medication changes, and every three

months for a person who is extremely stable and receiving psychotropic medications that do not have many side effects. Mikkelsen Tr. 3621:6-12.

599. Contrary to these accepted standards, CHDC's consulting psychiatrist acknowledged that he rarely sees anyone more than once a month. Mikkelsen Tr. 3631:25-3632:2. Moreover, the majority of the psychiatrist's follow-up visits occur below the standard at two-to-three-month intervals. Mikkelsen Tr. 3622:4-6. The psychiatrist even subjects residents whom he identified as experiencing a difficult psychiatric period to this substandard two-to-three-month follow-up practice. Mikkelsen Tr. 3623:23-3624:1. All these CHDC follow-up practices constitute substandard psychiatric care. Mikkelsen Tr. 3624:2-3.

600. CHDC's frequency of psychiatric follow up even fails Defendants' own purported standards. Defendants invoke the "Experts' Consensus Guidelines." Kastner Tr. 4149:15-17. These guidelines state that psychiatrists should "[r]eview regimen regularly (at least every three months and within one month of drug/dose change) to determine if medication is still necessary and if lowest optimal effective dose is being used." Kastner Tr. 6318:2-10.

601. There are many examples of CHDC substantially departing from generally accepted standards for resident monitoring. In CHL's case, after waiting five weeks to see CHL following his admission, and his near death from the side effects of psychotropic medication, the consulting psychiatrist scheduled CHL's next appointment for three months later. Mikkelsen Tr. 3679:2-4; Appx. at 5-8.

602. During a May 2009 psychiatric consult, CHDC's consulting psychiatrist identified TM as having potential psychosis and identified several possible factors affecting TM's condition. He did not, however, give any guidance to TM's treatment team regarding what to track in order to

establish or rule out this diagnosis. Holloway Tr. 2549:11, 2551:15-2553:9. Notwithstanding the uncertainty in TM's psychiatric condition, CHDC's consulting psychiatrist scheduled TM's next psychiatric appointment for two months later. Holloway Tr. 2553:2-5.

603. Defendants' consultant Dr. Kraus testified that his review of LW's psychiatric care indicated that LW had gone nine months between psychiatric visits. Kraus Tr. 6245:22-6247:2.

604. Defendants' consultant Dr. Kraus testified that his review of MB's psychiatric care indicated that MB had gone six months between psychiatric visits. Kraus Tr. 6252:1-16. Dr. Kraus further testified that MB was scheduled to go another three months between psychiatric visits, even though CHDC was changing her psychotropic dosages. Kraus Tr. 6253:12-22; *see also* Kraus Tr. 6255:20-23 (conceding that an earlier follow up was "not a bad idea").

605. Defendants' consultant Dr. Kraus testified that his review of resident CJ's records indicated that CJ had gone more than three months between psychiatric visits, even though CHDC's consulting psychiatrist had commented during CJ's last psychiatric visit that CJ had an increase in targeted behavior following a medication change. Kraus Tr. 6269:21-6270:5.

606. Defendants' consultant Dr. Kraus testified that his review of resident JM's records indicated that JM had gone more than four months since JM's last psychiatric visit, even though JM had diagnoses of autism, seizures, stable brain atrophy, and JM was receiving multiple psychiatric medications. Kraus Tr. 6304:21-6305:12.

607. Defendants' consultant Dr. Kraus testified that he found "a series of kids that had not been seen in six to nine months, and I brought this up." Kraus Tr. 6252:9-11. Dr. Kraus testified

that CHDC's delays in seeing youths at CHDC led him to recommend that CHDC obtain additional psychiatric services. Kraus Tr. 6253:6-11.

608. Rather than see residents on a timely basis, CHDC's consulting psychiatrist will recommend several medication changes, including classes of different medications in which the individual's response is more uncertain, based on rates of broadly categorized behavior categories or uses of restraint. He routinely makes such dangerous changes without spelling out a diagnostic formulation, identifying the target symptoms for a particular medication, or specifying the indications for medication changes. Holloway Tr. 2528:19-2529:5, 2538:4-14, 2569:10-2571:5; Mikkelsen Tr. 3622:10-15. As a consequence, CHDC places residents at risk of experiencing harmful reactions to medications or other changes in their condition because of significant changes in their medications without being seen by a psychiatrist for an extended period. This is a substantial departure from generally accepted professional standards of care. *See* FOF ## 509, 510 & 598. The CHDC consulting psychiatrist's recommendations sometimes involve making as many as four potential medication changes before the consulting psychiatrist even sees the individual again in two to three months. Mikkelsen Tr. 3622:15-18.

609. The consulting psychiatrist's July 2009 consulting note for BLH illustrates this dangerously substandard practice: "If we see no improvement in frequency of behavior reports, could consider 25-milligram increase in the thioridazine dosage in the morning as tolerated." Holloway Tr. 2571:15-2572:11. As Dr. Holloway testified, "Instead of Dr. Callahan coming in and assessing the individual and ruling out potential other variables in this example, such as akathisia . . ., the psych examiner comes in and . . . recommended an increase in thioridazine of 25 milligrams as noted per Dr. Callahan's last note. And [the psychology examiner] says: 'I

recommend an increase and will monitor for any effectiveness, decrease agitation, aggression, and any side effects.'" Holloway Tr. 2572:17-2573:2. In other words, in the interim between psychiatric visits, the psychology examiner, rather than the psychiatrist, initiated a change in BLH's psychotropic medication. Holloway Tr. 2572:17-2573:2. BLH represents just an example of this substandard practice at CHDC. Holloway Tr. 2576:5-7.

3) CHDC's Insufficient Availability of Psychiatric Services

610. CHDC's consulting psychiatrist does not work for CHDC anywhere near a minimally sufficient time to meet the needs of persons on his case load. Defendants' contract with him provides approximately a mere 18 hours a week of psychiatric consulting services to approximately 500 people diagnosed with co-occurring psychiatric diagnoses across three State institutions. Mikkelsen Tr. 3650:3-3651:2; Callahan Tr. 5374:13-21. This time is not nearly sufficient, particularly given the complexity of CHDC's population. Holloway Tr. 2511:24-2512:5, 2539:11-19. Mikkelsen Tr. 3651:3-10. CHDC residents' needs require the equivalent of a full-time psychiatrist to be on site. Holloway Tr. 2539:19-24. Defendant's consultant Dr. Louis Kraus testified that his assessment as to the adequacy of psychiatric services at CHDC was dependent upon CHDC's consulting psychiatrist working full-time at CHDC. Kraus Tr. 6361:15-18. Dr. Kraus wrongly assumed that CHDC's consulting psychiatrist worked full-time at the facility. Kraus Tr. 6361:15-18, 6368:1-6. Even based on the incorrect assumption that CHDC's consulting psychiatrist worked full-time at CHDC, Dr. Kraus concluded that "they could benefit from additional psychiatric care and [sic] something they should talk to the University about in regard to their contract." Kraus Tr. 6213:5-11.

G. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from CHDC's Failure To Provide Its Consulting Psychiatrist with Sufficient Training and Oversight.

611. CHDC's consulting psychiatrist has no formal training in treating individuals with developmental disabilities. Further, he is not board-certified in child and adolescent psychiatry and has had no formal training in treating children and adolescents. Yet, CHDC maintains that many of the children under his care have complex psychiatric histories. Further, CHDC provides no clinical oversight over its consultant psychiatrist or other mechanisms to address his deficiencies in training. *See* FOF ## 612-624.

612. Dr. Douglas Callahan is the consulting psychiatrist at CHDC. Callahan Tr. 5333:14-18. Dr. Callahan has responsibility for virtually all of CHDC's residents receiving psychiatric consultation services. Mikkelsen Tr. 3590:3-4, 3590:14-18; Holloway Tr. 2504:22-2505:10.

613. Although the consulting psychiatrist does not sign the actual orders for medication administration, CHDC's primary care physicians simply adopt his recommendations in virtually every instance. Mikkelsen Tr. 3590:4-8; Callahan Tr. 5374:9-12; Thomas Tr. 1734:3-22; Parmley Tr. 5471:10-13. As a practical matter, CHDC's consulting psychiatrist treats CHDC's residents. Mikkelsen Tr. 3655:9-17.

614. Dr. Callahan is not adequately trained or supervised to serve as CHDC's psychiatrist. A psychiatrist treating individuals at like those at CHDC should either have specialized training in serving persons with developmental disabilities or have supervision on the job that would constitute such training because individuals with developmental disabilities and psychiatric needs often have issues of assessment, diagnosis, and care that are distinct from individuals

without developmental disabilities. Mikkelsen Tr. 3639:10-19, 3640:6-25. CHDC's consulting psychiatrist admits that he has had no specialized training in providing psychiatric care to individuals with developmental disabilities. Callahan Tr. 5352:5-8; Mikkelsen Tr. 3638:13-16; US Ex. 763-1. Nor has he received on-the-job training in treating individuals with developmental disabilities. Mikkelsen Tr. 3640:20-3641:3. Nor is he supervised by someone who has had such training. Holloway Tr. 2505:13-14; Mikkelsen Tr. 3641:11-20; Thomas Tr. 1730:2-6.

615. CHDC's consulting psychiatrist is even less qualified to provide psychiatric care to CHDC children. The consulting psychiatrist provides psychiatric care to children as young as seven, and acknowledged that children admitted to CHDC often have had numerous prior psychiatric hospitalizations. Holloway Tr. 2513:8-9, 2510:2-4. CHDC currently houses approximately 50 children. A. Green Tr. 846:2-3; US Ex. 229. Approximately half of them are receiving psychotropic medications. Mikkelsen Tr. 3589:24-25. These individuals often are experiencing complex psychiatric disturbance and require specialty services. Holloway Tr. 2515:4-8.

616. Notwithstanding the complexity of children and adolescents at CHDC, CHDC's consulting psychiatrist is not board certified in child psychiatry. Callahan Tr. 5352:16-19; Holloway Tr. 2513:9-22; Mikkelsen Tr. 3638:13-19. CHDC's consulting psychiatrist has never participated in a child psychiatry residency program. Callahan Tr. 5353:21-5354:1; Mikkelsen Tr. 3641:9-10.

617. CHDC's consulting psychiatrist has had no formal training in child and adolescent psychiatry. Mikkelsen Tr. 3638:16-24; US Ex. 763-1. CHDC's consulting psychiatrist does not

consult with a child and adolescent psychiatrist to supplement his lack of training. Mikkelsen Tr. 3641:11-16; Holloway Tr. 2548:15-16.

618. The American Academy of Child and Adolescent Psychiatry has issued policy statements setting out the qualifications for psychiatrists treating children and adolescents needing institutional psychiatric care. US Ex. 870; Holloway Tr. 2515:25-2516:21. These policy statements instruct that, for children "under 14 years of age, a qualified psychiatrist is a child and adolescent psychiatrist who is board certified in child and adolescent psychiatry or a psychiatrist who, in addition to general psychiatry training, has successfully completed a training program in child and adolescent psychiatry accredited by the accreditation council of graduate medical education," and for persons "14 to 17 years of age or older, a qualified psychiatrist is a child and adolescent psychiatrist . . . or a general psychiatrist who has documented sufficient specialized training and experience in working with adolescents and their families on an inpatient treatment program and has demonstrated competence to examine and treat adolescents comprehensively." US Ex. 870; Holloway Tr. 2515:25-2516:21. CHDC's consulting psychiatrist lacks such qualifications. Holloway Tr. 2516:22-23.

619. CHDC's failure to provide psychiatric treatment to children and adolescents through a qualified psychiatrist substantially departs from generally accepted professional standards. Holloway Tr. 2621:4-9.

620. CHDC provides no clinical supervision or clinical oversight to the unqualified consulting psychiatrist. Holloway Tr. 2505:13-14; Mikkelsen Tr. 3639:23-3640:5, 3641:17-20. CHDC's consulting psychiatrist testified that the closest person to someone who exercised clinical oversight of him was Dr. Denise Thomas. Callahan Tr. 5376:7-9. Tellingly, Dr. Thomas

testified that she does not supervise CHDC's consulting psychiatrist, nor does anyone provide clinical oversight of CHDC's consulting psychiatrist. Thomas Tr. 1729:25-1730:6.

621. CHDC's consulting psychiatrist is not subject to formal, routine peer review. Holloway Tr. 2505:11-12; Mikkelsen Tr. 3641:21-22, 3645:14-3646:18; US Ex. 776.

622. CHDC has no policies and procedures governing psychiatric services. Holloway Tr. 2504:14-16.

623. The medication utilization of CHDC's consulting psychiatrist is not subject to review. Holloway Tr. 2596:16-21.

624. CHDC's failure to provide clinical supervision or clinical oversight to the unqualified consulting psychiatrist substantial departs from generally accepted professional standards. Holloway Tr. 2640:10-20, 2705:3-2706:5.

H. CHDC's Substantial Departure from Generally Accepted Professional Standards of Psychiatric Care Results in Harm to CHDC Residents from Lack of Coordination and Communication Regarding Psychiatric Care.

625. The failure of CHDC's clinicians to coordinate effectively to meet the needs of CHDC residents has contributed to the death of at least one resident and to multiple other breakdowns in care. CHDC's system of psychiatric care substantial departs for generally accepted minimum professional standards by not ensuring clinicians coordinate care resulting in dangerously uninformed treatment and medication decisions. *See* FOF ## 626-637.

626. CHDC resident CJ's death from Haldol shows the harmful effects of CHDC's failure to coordinate clinician services. Resident CJ died from neuroleptic malignant syndrome caused by Haldol, which CHDC inappropriately administered to suppress the side effects of another,

unnecessary medication, Keppra. *See* FOF # 509; Appx. at 2-5. There is no evidence that clinicians involved in her care communicated and coordinated to determine the necessity of the Keppra or the purported necessity of the Haldol which killed her. Appx. at 2.

627. Similarly, CHDC resident TN required blood transfusions to correct dangerously low platelets. CHDC clinicians knew that the psychotropic medication Depakote likely was causing TN's drop in blood platelets. Yet, TN's chart indicates that CHDC's clinicians did not know whether a neurologist had determined that TN continued to require the Depakote, which was started years earlier in response to possible seizures, and there is no evidence that CHDC clinicians coordinated to determine whether TN needed to receive the Depakote instead of one of several alternative medications. Appx. at 9-10.

628. CHDC clinicians need to work together on a systematic basis because CHDC residents receive numerous medications for varied medical issues. Holloway Tr. 2493:24-2494:1; Mikkelsen Tr. 3628:22-3629:10. The generally accepted systematic treatment process requires the psychiatrist to address the whole medical case, not just the psychiatric case, because of drug to drug interactions and side effects that may occur if one is receiving complex medication regimens. Holloway Tr. 2494:7-10. Changing even one medication can cause changes in the effects of other medications. Holloway Tr. 2494:11-2495:3, 2578:7-2579:5; Mikkelsen Tr. 3629:5-10. CHDC's records, however, indicate that there is no continuity between the medical and psychiatric disciplines and no meaningful coordination of care for overlapping medical and psychiatric conditions. Holloway Tr. 2506:20-2507:4. The cases of CJ and TN illustrate the associated harms. Appx. at 2-5, 9-10.

629. Because psychiatric and neurological medicines have overlapping effects on psychiatric and neurologic disorders, psychiatric and neurologic care must be closely coordinated. Mikkelsen Tr. 3629:11-15. This coordination needs to be memorialized in writing. Mikkelsen Tr. 3630:8-10. At CHDC, the consulting psychiatrist does not even speak with neurologists who provide care to persons on his case load. Holloway Tr. 2507:5-8; Mikkelsen Tr. 3630:11-20. CHDC's consulting psychiatrist admitted that his communication with other specialist clinicians treating individuals on his caseload is limited to reviewing their notes. Callahan Tr. 5375:1-11. A review of another clinician's notes is not a substitute for raising issues of overlapping care with another clinician and consulting about how that care will proceed going forward. Mikkelsen Tr. 3629:24-3630:10.

630. CHDC's physicians do not involve, or even contact, the consulting psychiatrist when emergency psychiatric care is provided to CHDC residents. Holloway Tr. 2512:6-2513:2. Indeed, the primary physician responsible for prescribing emergency psychiatric medications for CHDC residents does not know the consulting psychiatrist and has never even met him. Holloway Tr. 2507:21-2508:6.

631. The CHDC consulting psychiatrist is not notified when an individual on his caseload is given emergency psychiatric medication and does not learn about the emergency psychiatric medication until he next sees the individual for a regularly scheduled appointment. Holloway Tr. 2508:7-15.

632. The use of emergency psychiatric medication represents a significant clinical event. This emergency use should trigger the prompt involvement of the psychiatrist and the IDT to assess the reasons why the medication was administered and what the psychiatrist and IDT should do to

avoid having to use emergency psychiatric medication again. CHDC's consulting psychiatrist frequently delays addressing such serious clinical events until the resident's next clinic appointment, an unacceptable practice that substantially departs from generally accepted professional standards. Holloway Tr. 2508:16-2509:15.

633. CHDC's consulting psychiatrist does not participate in IDT meetings and does not consider himself to be a member of the IDT. Holloway Tr. 2505:15-18; Mikkelsen Tr. 3590:19-23.

634. The consulting psychiatrist's interactions with the individuals he treats, and staff responsible for their care, consists primarily of briefly meeting with the individual in an office, in the company of a direct care staff person and a psychology examiner. Holloway Tr. 2507:13-17; Mikkelsen Tr. 3590:8-11.

635. CHDC's consulting psychiatrist sees individuals in an office setting, rather than an environment more conducive to the individuals, even when doing so is known to be upsetting for the individual, to trigger aggressive behaviors, to be physically harmful to staff, and to likely reinforce the individual's problematic behaviors. Mikkelsen Tr. 3632:3-3635:5; US Ex. MC-4. This does not comport with generally accepted professional standards of care. Mikkelsen Tr. 3636:21-3637:15.

636. The consulting psychiatrist's lack of interaction with individuals' interdisciplinary teams is a departure from generally accepted professional standards of care. Mikkelsen Tr. 3627:17-23.

637. CHDC's consulting psychiatrist does not regularly interact with individuals' primary care providers to discuss cases in an organized way. Mikkelsen Tr. 3627:24-3628:3. This is a

departure from generally accepted professional standards of care. Mikkelsen Tr. 3628:3-6. This lack of structured interaction with medical providers complicates the important issue of ensuring that medical problems are accounted for in assessing the causes of a possible disorder. Mikkelsen Tr. 3628:11-21.

IX. CONCLUSIONS OF LAW– PSYCHIATRY

Defendants harm CHDC residents in multiple respects through grossly deficient psychiatric care, in violation of their constitutional rights. Under the Fourteenth Amendment's Due Process Clause, "adequate . . . medical care" is one of the care "essentials" that a state must provide to institutionalized individuals with development disabilities. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982); *see also Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983). Accordingly, Defendants violate the Due Process Clause when they provide care that substantially departs from professional standards. *Rennie*, 720 F.2d at 269; *see also Morgan v. Rabun*, 128 F.3d 694, 697-98 (8th Cir. 1997); *Heidemann v.Rother*, 84 F.3d 1021, 1029 (8th Cir. 1996).

When evaluating the professional judgment regarding the prescribing of psychotropic medication, courts should consider "whether and to what extent the patient will suffer harmful side effects." *Rennie*, 720 F.2d at 269. CHDC harms its residents, in violation of their constitutional rights, by failing to recognize or treat side effects and toxic levels of psychotropic medication, causing fatal and serious harm or risk of harm to residents, in a substantial departure from professional standards of psychiatric care. CHDC's only psychiatrist does not adequately monitor residents for side effects and medication levels; CHDC's direct care staff and on-call physician fail to detect side effects and toxic levels; and the facility itself maintains no overall

system of tracking risk factors that result from unmonitored administration of psychotropic medication.

CHDC also unlawfully harms its residents through other deficient psychiatric practices that substantially depart from generally accepted professional standards, namely: its use of clinically deficient diagnoses to justify medications; its unjustified medication practices (including to suppress other medication's side effects, in response to non-psychiatric environmental behaviors, and as chemical restraints); its clinically deficient assessments of medication efficacy; and its untimely psychiatric assessments and follow up care. To satisfy constitutional standards, treatment practices must reflect "professional judgment." *Youngberg*, 457 U.S. at 322-23. At minimum, evidence must show that such professional judgment was indeed exercised. *Id.* This standard is not met when a professional's decision substantially departs from generally accepted standards or practice. *Id.*; *see Thomas S. v. Flaherty*, 902 F.2d 250, 252-254 (4th Cir. 1990) (treating professional's decision not conclusive in determining whether professional judgment was indeed exercised). The foregoing evidence compellingly demonstrates such harmful departures.

Finally, CHDC violates its residents' constitutional rights to adequate psychiatric care through its use of a consultant psychiatrist who is not a professional qualified to treat children with developmental disabilities, who has had no training in providing psychiatric care to individuals with developmental disabilities, who is effectively providing treatment without clinical oversight, and who lacks sufficient time to meet individuals' needs. Professional decisions about the services a resident receives must be based upon the individual's needs, not available services or administrative convenience. *See Ohlinger v. Watson*, 652 F.2d 775, 779 (9th Cir. 1981) ("Lack of funds, staff or facilities cannot justify the State's failure to provide

appellants with that treatment necessary for rehabilitation."); *see also Thomas S. v. Flaherty*, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988) ("Professional judgment probably was not exercised 'if it was modified to conform to available treatment rather than appropriate treatment.'") (internal citation omitted); *Lelsz v. Kavanagh*, 629 F. Supp. 1487, 1495 (N.D. Tex. 1986) ("Evidence that the professional judgment was made to conform to what was available may indicate that the judgment was 'a substantial departure from accepted professional judgment, practice or standards.'"). Here, the evidence clearly establishes that psychiatric treatment is chronically and grossly delayed and provided by one psychiatrist with insufficient training or availability to meet the needs of the many CHDC residents on his caseload, in violation of their constitutional rights. *See Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1120-21 (9th Cir. 2003) (delays in providing pretrial detainees with access to mental health care violates Due Process Clause).

X. FINDINGS OF FACT – MEDICAL CARE

638. CHDC's medical care significantly and systemically departs from generally accepted professional standards of care. Mikkelsen Tr. 3573:22-3574:22. In particular, CHDC clinicians lack oversight and depend excessively on direct care staff to identify changes in health status. As a consequence, CHDC provides untimely care that has resulted in extraordinarily high rights of mortalities from normally nonfatal aspiration pneumonias and a strikingly young average age of death. *See* FOF ## 639-653.

A. CHDC Inappropriately Relies on Untrained Direct Care Staff To Identify Changes in Health Status.

639. At CHDC, primary care physicians do not make rounds on residential units. Thomas Tr. 1746:22-1747:3. Rather, CHDC gives untrained direct care staff responsibility for identifying individuals who require medical attention. Thomas Tr. 1747:4-10. CHDC's medical director

does not know whether CHDC provides direct care staff with any reference materials to consult to identify medical problems. Thomas Tr. 1747:11-15.

640. At CHDC, direct care staff do not have adequate training to recognize emerging medical problems. Mikkelsen Tr. 3655:7-8. At CHDC, primary care physicians typically see individuals only through a sick call process. Mikkelsen Tr. 3651:18-3653:1. CHDC's sick call system is not adequate, because the system relies too heavily on untrained direct care staff to make crucial medical observations. Mikkelsen Tr. 3653:15-24.

B. CHDC Exercises Insufficient Clinical Oversight.

641. CHDC's medical director does not exercise a significant supervisory and quality assurance role. She literally does not know anything about a variety of important issues that directly affect the quality of medical care. For instance, CHDC's medical director could not recall whether she reviews any assessments of hospitalization trends. Thomas Tr. 1750:1-5.

642. CHDC's medical director has no specialized training in treating individuals with developmental disabilities. Thomas Tr. 1724:22-25. Moreover, only one of CHDC's four primary care physicians has any specialized training in the provision of medical care to individuals with developmental disabilities. Thomas Tr. 1725:1-4; Parmley Tr. 5482:6-9.

643. CHDC gives the on-call physician, who has no specialized training in treating individuals with developmental disabilities, responsibility for seeing CHDC residents after hours and on weekends, and for treating them while hospitalized. Thomas Tr. 1725:22-24, 1726:11-16. This physician is effectively working around the clock, raising issues of fatigue and judgment. Mikkelsen Tr. 3655:22-3657:3. CHDC's medical director supervises the on-call physician. Thomas Tr. 1725:11-14. CHDC's medical director does not know why the on-call physician

does not attend CHDC medical peer reviews. Thomas Tr. 1729:3-10. She testified that she does not know this information because "[w]e never asked him." Thomas Tr. 1729:3-10. CHDC's medical director admitted that she did not "have a clue" regarding the accuracy of the on-call physician's estimate that approximately 70 percent of hospitalizations of CHDC residents relate to pneumonia. Thomas Tr. 1750:11-16.

644. CHDC's medical director testified that she did not know the accuracy of CHDC on-call physician's estimate that 20 percent of hospitalizations of CHDC residents relate to potentially fatal bowel obstructions. Thomas Tr. 1750:17-1751:4.

645. CHDC's medical director testified that she did not know whether CHDC had undertaken any studies regarding the causes of CHDC residents' deaths. Thomas Tr. 1751:8-10.

646. CHDC's medical director testified that she did not know what is the leading cause of death at CHDC. Thomas Tr. 1751:11-13.

647. CHDC's medical director knows little about CHDC's medication side effect control system. *See* FOF # 532.

648. CHDC's medical director testified that she was unaware of any instance in which CHDC had reason to even question the care provided by a CHDC doctor or nurse to a CHDC resident. Thomas Tr. 1751:14-18.

649. At CHDC, physicians as a group meet no more than monthly to discuss patient care. Thomas Tr. 1747:16-1749:11. This is insufficient. Mikkelsen Tr. 3654:14-18.

650. CHDC's medical director testified that she does not have responsibility for the overall care of CHDC residents. Instead, each physician is responsible for their own case load and "they have their malpractice insurance." Thomas Tr. 1751:19-1752:9.

C. CHDC's Bad Clinical Outcomes Confirm Its Deficiencies in Medical Care.

651. Based on a two-year period, the average age of death at CHDC is 46.5 years, which is shockingly young. Mikkelsen Tr. 3772:5-16. This is a significant deviation from the average age of death for persons with developmental disabilities residing in similar facilities. For instance, the average age of death in similar facilities in Massachusetts is approximately 71 years old. Mikkelsen Tr. 3772:16-18.

652. Almost two-thirds of CHDC's deaths are due to pneumonia or aspiration pneumonia. Mikkelsen Tr. 3772:18-22. This rate is unusually high. Mikkelsen Tr. 3776:11-16. By comparison, the percentage of individuals with developmental disabilities who died in Massachusetts from aspiration pneumonia ranged from approximately 9 to 12 percent for the years 2002-2007. Mikkelsen Tr. 3774:12-18, 3777:4-24.

653. Arkansas community providers, who serve individuals with the same types of disabilities and medical concerns as CHDC's residents, testified that they have not had any clients die of aspiration pneumonia. Alberding Tr. 1396:4-7; Bland Tr. 883:8-17; Lambert Tr. 1871:3-8.

654. CHDC's substandard medical services cause this high death rate from aspiration pneumonia. CHDC's clinicians recommend use of hospice services before the illness appears to be terminal. Mikkelsen Tr. 3772:23-3773:6. CHDC's clinicians recommend use of hospice for non-terminal respiratory illnesses. Mikkelsen Tr. 3773:7-15. Dr. Eldon Schulz, medical director of the Arkansas Division of Developmental Disabilities, testified that aspiration pneumonia is

"absolutely not" normally a terminable condition that would cause someone to seek hospice care. Schulz Tr. 6187:4-7. CHDC physician, Dr. Parmley, admitted that aspiration pneumonia is a "treatable condition" that should not lead to death, unless it was not caught early or treated properly. Parmley Tr. 5453:10-18. Dr. Parmley admitted that CHDC residents have died following hospitalization, with an admission diagnosis of aspiration pneumonia. Parmley Tr. 5453:18-24.

XI. CONCLUSIONS OF LAW – MEDICAL CARE

CHDC residents have a constitutional right to medical services to help maintain or improve functions and to prevent harm from serious medical conditions. See Youngberg, 457 U.S. at 315, 324 (an institutionalized person has a constitutionally protected right to adequate medical care). A facility for individuals with developmental disabilities must provide these medical services through qualified and trained staff, both at a professional and direct care level. Id. at 323 n.30 (even for day-to-day matters, untrained staff should be supervised by a qualified professional).

Defendants' deficient medical care has harmed CHDC residents, in violation of their constitutional rights, by failing to provide medical services to address their serious medical needs. Defendants have not provided the minimum level of treatment required to address CHDC residents' serious medical needs. Medical care at CHDC is hierarchical, with heavy reliance on the identification of issues by unqualified direct care staff, and inadequate access to care from qualified professionals. The barriers in place mean that many residents with serious needs do not receive necessary treatment until after their conditions have already deteriorated. Professional staff do not address serious conditions in an interdisciplinary and effective manner. Instead, a

generic administrative process substitutes for clinical interventions in response to significant health risks.

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XII. FINDINGS OF FACT – PHYSICAL AND NUTRITIONAL MANAGEMENT

655. Defendants subject CHDC residents to harm, and unreasonable risk of harm, from physical and nutritional management services that substantially depart from generally accepted minimum professional standards. CHDC residents suffer abnormally high rates of choking, aspiration pneumonia, bone fractures, and skin pressure sores. CHDC's failure to implement and monitor the residents' physical and nutritional management plans, provide adequate competency-based training, and provide a complete or timely response to incidents, puts CHDC residents at an unreasonable risk for choking, aspiration pneumonia, bone fractures, and skin pressure sores. *See* FOF ## 656-713.

A. Expert Carly Crawford Provided Credible Expert Testimony of CHDC's Deficiencies in Physical and Nutritional Management.

656. Expert witness Carly Crawford evaluated CHDC's provision of physical and nutritional management and therapy services, including occupational therapy, physical therapy, and speech-language pathology. Crawford Tr. 2740:9-13.

657. Ms. Crawford's extensive experience in physical and nutritional management qualifies her to evaluate CHDC. US Ex. 952. She is a licensed occupational therapist, with an undergraduate degree in deaf education and a master's degree in occupational therapy. Crawford Tr. 2743:6-23. Ms. Crawford has education and experience in health systems, anatomy, physiology, and health risks related to physical and nutritional management, speech-language pathology, and physical therapy. Crawford Tr. 2742:21-2743:4; US Ex. 952. She has lectured, conducted workshops, and provided clinical instruction in physical and nutritional management. Crawford Tr. 2745:10-13; US Ex. 952. Ms. Crawford has worked extensively as a consultant

(on behalf of states and the Department of Justice), provided technical assistance, and acted as a court monitor in the area of physical and nutritional management. She has provided expert consultation to at least 32 ICF/MR facilities in 19 different states. Crawford Tr. 2747:9-22.

658. Ms. Crawford toured CHDC initially in 2003, then again in July and September of 2009. Crawford Tr. 2741:18-24. During her review, Ms. Crawford interviewed CHDC staff, reviewed extensive documents, and observed and interacted with CHDC residents. Crawford Tr. 2752:22-2753:7; 2753:22-2754:11; 2755:18-2756:14.

659. As a result of her review, Ms. Crawford concluded that CHDC has major deficiencies causing residents to suffer preventable harm from choking incidents, aspiration pneumonia, bone fractures, and skin pressure ulcers. Crawford Tr. 2756:18-2757:1. CHDC's deficient practices regarding staff implementation of physical and nutritional management plans, training, and monitoring caused these harms. Crawford Tr. 2756:18-2757:4.

660. CHDC's practices with regard to choking, aspiration pneumonia, bone fractures, and skin pressure ulcers violate generally accepted minimum professional standards because CHDC staff fail to: (1) properly implement the residents' physical and nutritional management plans; (2) monitor staff implementation and effectiveness of the plans; (3) provide adequate competency-based training; and (4) provide a complete or timely response to incidents. Crawford Tr. 2757:5-16, 2897:1-17; *see also* Crawford Tr. 2751:20-2752:1 (defining generally accepted minimum professional standards). These failures resulted in harm, and unnecessary risk of harm to residents, as demonstrated by the high numbers of incidents of choking, aspiration pneumonia, fractures, and pressure ulcers. Crawford Tr. 2897:18-22.

B. CHDC's Substantial Departure from Generally Accepted Professional Standards of Physical and Nutritional Management Results in Harm to CHDC Residents from Choking.

661. CHDC has a "shocking" number of choking incidents for a facility of its size. Crawford Tr. 2768:10-17, 2897:18-22. In the first 9 months of 2009, at least 13 CHDC residents suffered choking incidents. Crawford Tr. 2767:15-21. Previous years also showed shockingly high numbers, with 18 CHDC choking incidents in 2008, and 24 in 2007. Crawford Tr. 2767:5-14; US Ex. 986. Other facilities have significantly less choking incidents. Crawford Tr. 2768:10-24.

662. CHDC's substantial departure from generally accepted professional standards requiring that direct care staff properly implement the residents' eating plans, that CHDC monitor direct care staff's implementation of the plans, that CHDC employ competency-based training on eating plans, that CHDC accurately document eating plans, and that CHDC take timely remedial steps, caused resident harm, and increased risk of harm, from choking and aspiration. *See* FOF ## 663-697.

663. CHDC's high number of choking incidents results from CHDC staff failing to implement the residents' eating plans as the plans are written by the professional therapist staff. Crawford Tr. 2769:5-10.

664. Deficiencies in direct care staff training and lack of direct care staff monitoring cause CHDC's failure to implement the plans consistently. Crawford Tr. 2769:5-25, 2771:17-18.

665. CHDC employs substandard, non-competency-based staff training on mealtime safety plans. Crawford Tr. 2771:19-20. Competency-based training requires, *inter alia*, staff to demonstrate that they can actually perform the skill. Crawford Tr. 2772:22-2773:1.

666. CHDC speech-language pathologist Cynthia Johnson confirmed that unit supervisors, rather than professional staff, are responsible for training direct care staff on mealtime safety plans. C. Johnson Tr. 5398:8-25, 5425:18-5426:12. Professional staff merely train the unit supervisors, and currently, this training is not competency based. C. Johnson Tr. 5398:2-7, 5425:18-5426:10.

667. Staff who assist residents with eating need skill-competency-based training on mealtime safety plans to minimize the individual resident's risk of choking, aspiration, or death. Crawford Tr. 2771:19, 2771:23-2772:4. Competency-based training ensures that staff can demonstrate performance of the particular skills outlined in the resident's mealtime safety plan. Crawford Tr. 2771:19, 2772:5-12.

668. Professional staff's monitoring of direct care staff reduces the risk of resident harm by ensuring that direct care staff are correctly implementing the mealtime safety plans and by facilitating coaching to address plan implementation deficiencies. Crawford Tr. 2773:14-17, 2774:16-18, 2847:22-23, 2848:8-22. This monitoring also enables professional staff to assess how the mealtime system is functioning and identify weaknesses. Crawford Tr. 2773:14-17, 2774:18-2775:9.

669. Defendants' occupational therapy consultant agreed that direct care staff should be trained on the specific programs for individuals in their care, which should include some level of supervisor observation to ensure that the staff are complying with treatment plans. Schmeler Tr. 3508:7-24.

670. Due to inadequate training and lack of monitoring, CHDC direct care staff demonstrated an inadequate understanding of, and the inability to follow, residents' mealtime safety plans. Crawford Tr. 2773:2-11.

671. For example, in June 2007, CHDC resident VB choked on pizza rolls in her living unit. Crawford Tr. 2775:22-2776:5; US Ex. 1017. VB was prescribed a blended diet because she does not chew her food and tends to swallow pieces of food whole. Crawford Tr. 2776:6-13. When CHDC staff found that VB had stuffed pizza rolls into her mouth, the staff offered VB water before assessing if VB was choking or taking emergency measures. Crawford Tr. 2776:14-15, 2776:21-23. This incident demonstrated that CHDC staff were not properly supervising VB and were not able to properly implement VB's mealtime safety plan. Crawford Tr. 2777:2-11. Offering water to an individual on a blended diet who had food in her mouth is "the last thing" that staff should have done because water could have caused the food to lodge in VB's trachea. Crawford Tr. 2777:2-3, 2777:7-11, 2777:19-2778:3. By offering VB water before taking proper emergency precautions, CHDC staff violated minimum professional standards and put VB at great risk of harm. Crawford Tr. 2778:4-8.

672. Similar to the VB incident above, in June 2007, CHDC resident LB choked on a piece of meat at lunch. Crawford Tr. 2778:14-23; US Ex. 1019. LB was alone at a table. When another resident sat down, LB grabbed a piece of meat off the other resident's plate and put it in her mouth. Crawford Tr. 2779:1-8. Staff gave LB the liquid "Ensure" to wash the meat down and, after the liquid ran back out of LB's mouth, performed the Heimlich maneuver. Crawford Tr. 2779:9-16. Although LB suffered no permanent harm, the "risk of death was very imminent." Crawford Tr. 2779:1-2, 2779:19-20. LB's mealtime safety plan specifically stated that she

attempts to take food, particularly diced or textured foods, from other people and that she had a history of choking on these foods. Crawford Tr. 2779:19-2780: 6. The mealtime safety plan also stated that LB was on a blended diet, should be carefully monitored at meals, should only be seated with other individuals with blended or chopped foods, and should be escorted from the dining room. Crawford Tr. 2780:9-14. Resident LB's Quick Reference Guide ("QRG"), however, contained information only about LB being escorted from the dining room. Crawford Tr. 2781:3-5. This example illustrates CHDC staff's failure to implement a mealtime safety plan as written, staff's poor supervision of residents, and CHDC's inconsistent guidance to staff regarding a resident's risks that would allow staff to protect CHDC residents from harm, such as choking. Crawford Tr. 2781:12-18.

673. On August 4, 2009, CHDC resident JR "strangled on rice, coughing with such force that he vomited." Crawford Tr. 2784:11-21; US Ex. 988. The therapist noted that although staff are supposed to sit with JR during his meals due to his tendency to eat rapidly and stuff food into his mouth, the therapist could not determine if staff were sitting with JR during the incident. Crawford Tr. 2784:11-12, 2784:11-25-2785: 4. The CHDC dietician did not notify the speech-language pathologist of the incident for 6 days, and the speech-language pathologist did not conduct a post-event observation of JR until 7 days after the choking. Crawford Tr. 2788:5-13. A speech-language pathologist should evaluate a choking victim before his next meal so that staff can implement strategies and changes to protect the resident from another choking episode. Crawford Tr. 2789:2-10. JR's interdisciplinary team did not meet for a special staffing regarding the incident until 9 days after JR choked. The interdisciplinary team should meet within 24 hours of a choking event to discuss what occurred, determine if assessments need to be done, and

provide timely follow-up. Crawford Tr. 2786:17-2787:5. Despite the fact that JR had known tendencies to eat too fast and stuff food into his mouth, the interdisciplinary team did not discuss any strategies or possible interventions to address those tendencies to attempt to reduce JR's risk of choking. Crawford Tr. 2787:12-2788:4. This example illustrates CHDC's staff failure to implement a mealtime safety plan as written, inadequate training on the mealtime safety plan, and substandard remedial action. Crawford Tr. 2789:14-2790:7.

674. On October 8, 2008, CHDC resident FJ experienced a choking event. Crawford Tr. 2790:18-20; US Ex. 1022. The speech-language pathologist did not conduct a post-choking observation of FJ for 5 days, and FJ's interdisciplinary team waited 6 days to hold a special staffing. Crawford Tr. 2793:10-12. On October 29, 2008, FJ's interdisciplinary team wrote that FJ should receive a swallow study in the next 45 days. Crawford Tr. 2791:8-13. A swallow study is an important assessment tool to determine problems, which may not be clear during a visual assessment, that an individual is experiencing with swallowing, chewing, potential aspiration, or difficulty delivering food to the esophagus. Crawford Tr. 2791:20-25-2792:2. When prompted by a choking event, the swallow study should occur quickly—anywhere from two days to two weeks. Crawford Tr. 2792:13-20. By allowing 66 days before a swallow study was required for FJ, CHDC violated generally accepted minimum professional standards. Crawford Tr. 2792:13-20. This incident also demonstrates substandard, untimely follow-up by the speech-language pathologist and FJ's interdisciplinary team. Crawford Tr. 2794:10-12.

675. On August 16, 2009, CHDC resident HO coughed and spit up some meat and bread during lunch. Crawford Tr. 2795:20-24; US Ex. 987. CHDC staff were supposed to position HO appropriately in his wheelchair during meals due to his medical diagnosis of GERD.

Crawford Tr. 2796:3-22. During this near choking event, however, CHDC staff had seated HO in a recliner while assisting HO to eat. Crawford Tr. 2795:20-2796: 2. After staff's failure to follow HO's plan, CHDC should have conducted an in-service training to explain why HO is at risk, why eating in the recliner is dangerous for HO, and to emphasize the importance of HO's proper alignment in the wheelchair during meals. Crawford Tr. 2797:3-17. Generally accepted minimum professional standards require that such training be competency-based to allow staff to demonstrate that they understand and can actually implement HO's mealtime safety plan. Crawford Tr. 2797:21-23, 2800:9-16. Instead, CHDC merely asked HO's staff to read and sign a statement that reminded them that HO should eat while seated in his wheelchair. Crawford Tr. 2798:1-4; 2799:10-24. Moreover, CHDC did not provide this substandard training timely after the choking. Crawford Tr. 2799:3-9. CHDC did not implement this substandard training until four days after the choking, and even more unacceptable, some staff did not even sign the statement until almost a month after the incident. Crawford Tr. 2798:4-9.

676. HO experienced another coughing/choking event at breakfast less than a month later in September 2009. Crawford Tr. 2801:7-10; US Ex. 987. Although HO had two events in a month's time, CHDC kept HO's choking risk level at "low." Crawford Tr. 2802:22-2803:6. CHDC instituted no additional monitoring or different strategies after the first incident, which could have prevented or minimized the second incident. Crawford Tr. 2802:4-21.

677. In January 2008, CHDC resident AR died of respiratory failure following a choking incident. Crawford Tr. 2803:18-2804:13; US Ex. 1023. CHDC staff left AR in the dayroom unsupervised, and then found AR on the kitchen floor with her mouth full of bologna. Crawford Tr. 2804:1-9. AR was prescribed a "diced diet" and had a history of filling her mouth too full,

eating fast, and swallowing without chewing. Crawford Tr. 2805:1-2806:1. CHDC also knew of two other incidents in the past year where AR had gone into the kitchen and grabbed food. Crawford Tr. 2806:4-7. AR died because CHDC staff failed to sufficiently supervise her. Crawford Tr. 2808:22-25. Beyond the tragic death, this example shows that CHDC failed to train staff sufficiently to understand AR's need for ongoing supervision to ensure that she did not take food from the kitchen. Crawford Tr. 2811:6-13. Despite the serious and tragic nature of AR's death, the Central Dysphagia Committee's meeting minutes note only that AR "expired as a result of choking." This quality assurance/improvement committee made no indication of any further evaluation of the incident or any discussion of systems changes, training, or monitoring that CHDC could institute to avoid future deaths and serious harms. Crawford Tr. 2808:15-2809:7; US Ex. 1052. CHDC's failure to take precautions to minimize AR's risk of harm, and the Dysphagia Committee's inadequate reaction, mark a significant departure from minimum acceptable professional standards. Crawford Tr. 2809:8-10, 2811:1-5.

678. To keep residents safe from risks of choking and aspiration, CHDC must adhere to generally accepted minimum professional standards, which require competency-based training, consistent monitoring and review, informal spontaneous coaching, staff diligence to follow the mealtime safety plans, and consistency in the paperwork that outlines the risks and plan for staff. Crawford Tr. 2848:23-2849:22.

C. CHDC's Substantial Departure from Generally Accepted Professional Standards of Physical and Nutritional Management Results in Harm to CHDC Residents from Aspiration Pneumonia.

679. Many CHDC residents die or are hospitalized for aspiration pneumonia, respiratory failure, or other pneumonia-related or respiratory-related causes. CHDC's substantial departure

from generally accepted professional standards that require CHDC to timely review pneumonia related cases, CHDC direct care staff to properly implement residents' eating plans, CHDC to properly train and monitor direct care staff, and CHDC to keep accurate, consistent documentation of residents' safety precautions, puts residents at an increased risk of harm from aspiration pneumonia. *See* FOF ## 680-697 .

680. CHDC residents suffer from a significant number of pneumonia cases. Crawford Tr. 2819:21-2820:2. Indeed, almost two-thirds of CHDC's deaths are due to pneumonia or aspiration pneumonia. Mikkelsen Tr. 3772:10-22. This rate is unusually high. Mikkelsen Tr. 3776:11-16, 3774:12-18, 3777:4-24 (comparing to Massachusetts rate of approximately 9-12% for the years 2002-2007). In a 2-year period, from approximately June 2007 through June 2009, 17 CHDC residents died of aspiration pneumonia, respiratory failure, or other pneumonia-related or respiratory-related causes. Crawford Tr. 2814:19-25. Many of these residents were extremely young to die from respiratory conditions. Crawford Tr. 2815:1-4. By comparison, the community providers testified that they could not remember any of their clients ever dying from aspiration pneumonia. Bland Tr. 883:8-17; Alberding Tr. 1396:4-7; Lambert Tr. 1871:3-8.

681. From June 2007 to July 2009, CHDC hospitalized 60 residents for pneumonia or aspiration pneumonia. Crawford Tr. 2817:14-25; US Ex. 1037.

682. Beyond the risk of death, CHDC residents suffering repeated episodes of pneumonia are at risk of harm because the repeated pneumonias compromise the residents' ability to exchange air and desensitize the residents to incidents of aspiration. Crawford Tr. 2822:2-17.

683. Generally accepted professional standards dictate that a facility's dysphagia review committee should thoroughly review any instance of pneumonia to evaluate all of the other

health risk indicators that may be complicating the resident's health, to determine if the facility should implement strategies to either prevent or minimize the risk of future pneumonias, and to address the immediate needs of a resident who is coming back from the hospital who may need special positioning, supports, or attention at mealtime. Crawford Tr. 2820:3-19. The facility should clearly plan how professional staff and direct care staff will collaborate to ensure that the resident stays safe and recovers following discharge from the hospital. Crawford Tr. 2820:12-24.

684. Contrary to these generally accepted practices, CHDC's Central Dysphagia Committee did not begin to review individual cases of pneumonia until January 2009. Crawford Tr. 2820:3-8.

685. Even now, the Central Dysphagia Committee reviews individuals with chronic pneumonia only once per year. Crawford Tr. 2764:20-21, 2765:18-19. CHDC should review residents at high risk for pneumonia, or with repeated occurrences of pneumonia, frequently throughout the year. Crawford Tr. 2765:20-2766:3, 2823:11-24. The Central Dysphagia Committee does not meet frequently enough and does not meet on a timely basis following significant dysphagia events. Crawford Tr. 2765:6-15, 2766:3-8.

686. CHDC fails to meet generally accepted minimum professional standards for minimizing aspiration pneumonia risk by failing to adequately train staff to adequately implement mealtime safety plans, recognize aspiration risks, and employ strategies to prevent or minimize residents' aspiration. Crawford Tr. 2823:7-18; *see also* L. Henderson Tr. 6428:16-18 (CHDC Dysphagia Committee chairwoman's statement that CHDC nurses do not proactively monitor residents with repeated pneumonia to "catch signs and symptoms before pneumonia.")

687. CHDC further fails to meet generally accepted minimum professional standards for minimizing aspiration pneumonia risk by failing to have professional staff properly monitor whether treatment plans meet the residents' needs and whether staff implement the plans correctly. Crawford Tr. 2823:11-24.

688. Improper positioning puts CHDC residents at risk for gastroesophageal reflux ("GERD"), difficulty swallowing, and aspiration. Crawford Tr. 2824:16-24. Customizing wheelchairs and proper positioning devices help residents by improving posture alignment, pressure management, body function, comfort, bowel and bladder management, and pain reduction. Schmeler Tr. 3485:18-3486:18. Defendants' consultant agreed that proper wheelchair fit makes up a "critical part" of a treatment plan and proper alignment is important during and outside of meal times. Schmeler Tr. 3501:2-9; L. Hancock Tr. 5277:7-16.

689. CHDC's physical therapy supervisor admitted that CHDC has no policy or formal process of monitoring residents' positioning and that the physical therapy department does not monitor residents during meals. L. Hancock Tr. 5294:15-21, 5303:25-5304:3, 5306:18-23. The physical therapy department also performs no monitoring of after-meal positioning to ensure proper precautions against GERD. L. Hancock Tr. 5305:22-25. The only monitoring the physical therapists perform are informal "spot checks." L. Hancock Tr. 5294:9-5295:9. In addition, beyond the new employee orientation training, the physical therapy department has not provided any formal training on positioning in recent years. P. Hackett Tr. 4845:23-25, 4846:8-4847:8.

690. CHDC often fails to position residents correctly. Crawford Tr. 2825:3-17. Ms. Crawford observed staff allow improper positioning of many CHDC residents during and outside of meal

times. Crawford Tr. 2825:13-17. This improper positioning demonstrates that CHDC direct care staff fail to position residents according to the residents' positioning plans as prescribed by the professional staff. Crawford Tr. 2952:13-2953:3.

691. Ms. Crawford testified to several examples of staff allowing residents to eat in dangerous improper positions. Ms. Crawford observed CHDC resident JS eating in the cafeteria. Crawford Tr. 2828:10. During the entire meal, JS sat slumped way over in her wheelchair with her head off to the right side over the armrest. Crawford Tr. 2828:6-12. A CHDC staff member assisted JS to eat in this improper position without ever attempting to reposition JS to correct her posture or alignment. Crawford Tr. 2828:19-24. JS was hospitalized for aspiration pneumonia both before (from November 19-December 3, 2008) and after (from November 29-December 17, 2009) Ms. Crawford observed JS's improper positioning. Crawford Tr. 2827:13-24; US Exs. 1051-6 & 1051-7. JS was also showing signs and symptoms of decline, dementia, and Alzheimer's. Crawford Tr. 2828:25-2829:2. Because these factors put JS at risk for aspiration, the staff member should have stopped the meal and repositioned JS. Crawford Tr. 2829:1-7.

692. In July 2009, Ms. Crawford also observed CHDC resident JG improperly positioned during a meal. Crawford Tr. 2829:16-19, 2830:8-12. JG was leaning off to the side, with no foot support, and her head turned and back in hyperextension throughout the meal. Crawford Tr. 2829:16-19, 2830:8-12. JG's mealtime safety plan stated that she was to be upright in her wheelchair for meals and identified her as being at high risk for choking and aspiration. Crawford Tr. 2831:15-19. The staff did not adjust JG's position, did not modify his own position to make eating easier for JG, and did not direct the spoon in a way that would help JG turn her head to be better aligned. Crawford Tr. 2829:16-19, 2830:12-17. JG's example

demonstrates CHDC's poor staff training and lack of staff supervision. Crawford Tr. 3831:13-23.

693. In September 2009, Ms. Crawford observed JG again and saw that she was seated with a four-to six-inch gap between her pelvis and the back of the chair. Crawford Tr. 2829:16-18, 2830:23-25. Because of this gap, the wheelchair was not providing JG with adequate postural support. Crawford Tr. 2831:3-5. This poor positioning violates both CHDC's guidelines and generally accepted minimum professional standards. Crawford Tr. 2830:25-2831:3.

694. Ms. Crawford also observed staff improperly position another resident, SB, in September 2009. Crawford Tr. 2833:6-17. Resident SB's mealtime safety plan states that staff should assist her to eat with her head "at midline," so she does not need to turn or lift her head when eating. Crawford Tr. 2832:1-23. In July 2009, CHDC staff fed SB while standing on her right and holding SB's forehead so that her head was turned to the right and pushed back into hyperextension, which increases SB's risk of aspiration. Crawford Tr. 2832:12-18. Ms. Crawford observed SB make an "effortful" swallow during that meal. Crawford Tr. 2832:7-12. During another meal, staff provided SB with liquids that were not thickened to the proper consistency outlined in SB's mealtime safety plan. Crawford Tr. 2833:18-2834:1. CHDC's failure to ensure that SB is fed in the correct position and provided with liquids at the correct consistency heightened SB's risk of aspiration. Crawford Tr. 2834:19-22. The supervisor in SB's living unit stated that any staff member working with a resident should have read the resident's mealtime safety plan and signed the training record to confirm such review prior to assisting the resident with meals. Crawford Tr. 2834:2-6. The staff member who was assisting SB was not listed on SB's training sheet, and no other evidence indicated that the staff had read

or received any training regarding SB's mealtime safety plan. Crawford Tr. 2834:7-11. This example demonstrates that CHDC fails to meet generally accepted minimum professional standards because staff are not following the residents' mealtime safety plans and that the lack of competency-based training regarding the mealtime safety plans is placing residents at risk of harm. Crawford Tr. 2834:14-2835:8.

695. In addition to SB, staff put other CHDC residents at risk for choking and aspiration by failing to properly thicken liquids according to residents' eating safety plan. For example, Ms. Crawford witnessed CHDC classroom staff preparing a beverage at the wrong consistency for resident BC. Crawford Tr. 2837:19-2838:4. Although the staff member thickened BC's beverage to only "nectar" thick, instead of "pudding" thick as BC's mealtime safety plan required, no other CHDC staff intervened. Crawford Tr. 2838:3-6. Because nectar thick liquids are dangerous for BC, Ms. Crawford intervened by asking the staff about the correct consistency; the staff needed to consult the mealtime safety plan to learn that BC required a pudding thick consistency. Crawford Tr. 2838:8-13. Even then, the staff still was unable to thicken BC's beverage correctly. Crawford Tr. 2838:12-22. Ms. Crawford also observed CHDC resident VW drinking "thin" liquids even though VW was prescribed "honey" thick liquids, presented a high risk for choking, and had already experienced two choking events that year. Crawford Tr. 2843:14-21. These examples further demonstrate that CHDC fails to meet generally accepted minimum professional standards because the lack of competency-based training, poor supervision, and insufficient monitoring of staff implementation of mealtime safety plans result in CHDC staff who do not or cannot follow the residents' mealtime safety plans, which places residents at risk of harm. Crawford Tr. 2839:17-2840:18, 2843:22-2844:4.

696. In another example of staff not adhering to mealtime safety plans, Ms. Crawford observed resident DL quickly eating his breakfast in just seven minutes. Crawford Tr. 2845:19-2846:1. Although CHDC has identified DL as at "high risk" for choking and DL's mealtime safety plan specifically stated that he should eat at a slow pace, take small bites, and receive encouragement to alternate each bit of food with fluids, no CHDC staff intervened to redirect him or encourage a slower pace. Crawford Tr. 2846:1-6. This example demonstrates CHDC's departure from generally accepted minimum professional standards and the resulting higher risk of a dangerous choking or aspiration event for DL. Staff should have intervened to properly implement DL's mealtime safety plan and prevent a high risk resident from eating too fast. Crawford Tr. 2846:12-22.

697. CHDC also puts residents at risk of harm by inconsistently documenting residents' eating safety precautions. Multiple discrepancies existed between residents' QRGs and their eating plans, both of which should provide consistent information to staff on a resident's eating precautions. Crawford Tr. 2780:2, 2781:1-9, 2844:5-21. These discrepancies result in risk of harm to residents from staff confusion and incorrect plan implementation. Crawford Tr. 2781:5-9. Generally accepted minimum professional standards require that CHDC use consistent and accurate documentation. Crawford Tr. 2847:7-9.

D. CHDC's Substantial Departure from Generally Accepted Professional Standards of Physical and Nutritional Management Results in Harm to CHDC Residents from Fractures.

698. CHDC residents identified as at greater risks for bone fractures still suffer an alarming number of fractures, with many suffering multiple fractures. CHDC's substantial departure from generally accepted professional standards requiring that staff give heightened attention to

"high risk" residents, that CHDC provide accurate, consistent fracture risk information to staff caring for the residents, and that CHDC provide staff with in-depth and comprehensive training results in fractures, and an increased risk of fractures. *See* FOF ## 699-706.

699. Many CHDC residents are at an increased risk for bone fractures due to osteoporosis or osteopenia, balance problems, or issues with aggressive behavior. Crawford Tr. 2851:22-2852:6.

700. CHDC identified approximately 373 residents as being at "greater risk" for fractures, designating 191 of those residents at "high risk" and the remaining residents as "increased risk" for fractures. Crawford Tr. 2852:23-2853:21; US Ex. 953-1. CHDC residents identified as greater risks still suffer an alarming number of fractures.

701. From June 2007 through September 2009, 24 CHDC residents identified as at "increased risk" for fractures suffered 31 fractured bones. Crawford Tr. 2855:24-2856:2; US Ex. 997. Five of those individuals suffered multiple fractures during that time. Crawford Tr. 2855:13-19.

702. Although resident HCT had experienced 17 fractures since March 1993, including 4 from June 2007 through September 2009, CHDC designated her only as being at "increased risk" for fractures, rather than "high risk." Crawford Tr. 2858:19-2859:20.

703. From June 2007 through September 2009, 20 CHDC residents identified as at "high risk" for fractures experienced 24 fractures, including at least 2 residents with multiple fractures. Crawford Tr. 2860:9-15. Staff should have a heightened awareness of individuals who have been designated as being at "high risk" for fractures and should pay particular attention to protect those individuals from risk of injury due to fractures. Crawford Tr. 2861:1-8.

704. From June 2007 through September 2009, 20 CHDC residents who use wheelchairs as their primary form of mobility experienced fractures. Crawford Tr. 2863:2-7. During the same

time, 13 CHDC residents who use wheelchairs for longer distance transport suffered fractures. Crawford Tr. 2863:8-9. These residents with limited mobility depend on CHDC staff and require staff attention and assistance for tasks such as bathing and transferring to and from bed. Crawford Tr. 2863:11-25.

705. CHDC fails to provide accurate, consistent fracture risk information to staff. To provide safe care, generally accepted minimum professional standards require that CHDC provide staff with correct information about the accurate risk levels assigned to each resident. Crawford Tr. 2864:1-10. When comparing the QRGs with the "greater risk" for fractures list, Ms. Crawford found that 88 residents who were identified as being at "increased" or "high" risk for fractures had no fracture risk included in their QRGs, and an additional 39 residents had inconsistencies between the QRG and the fracture list. Crawford Tr. 2865:11-21. Tellingly, despite resident HCT's serious history of 17 fractures, HTC's QRG contained no information regarding fracture risk. Crawford Tr. 2865:22-25.

706. On October 25, 2007, CHDC resident KB was screaming and crying when CHDC staff moved her and provided her personal care, and KB had been fussy for several days. Crawford Tr. 2867:13-20; US Ex. 21-3. Despite an x-ray revealing KB suffered pain from a fractured femur, the CHDC doctor did not treat the femur fracture as a medical emergency. CHDC merely admitted KB to the infirmary and scheduled a surgery for nearly a month later, on November 19, 2007. Crawford Tr. 2867:23-2868:5. Although KB had been "hollering continuously and crying," none of the six staff who worked with her observed any injury to KB. Crawford Tr. 2868:6-14. CHDC found that the exact cause of the injury could not be determined. Crawford Tr. 2868:18-21. Despite the seriousness of KB's fractured femur, CHDC's response was only to

provide 14 CHDC staff members with a 5-minute in-service training on careful handling of residents when providing personal care, bathing, lifting, or positioning. Crawford Tr. 2868:15-2869:8. Generally accepted minimum professional standards require a much more in-depth and comprehensive training to adequately address the risks to KB and proper techniques for avoiding future injuries. Crawford Tr. 2869:9-2870:20.

E. CHDC's Substantial Departure from Generally Accepted Professional Standards of Physical and Nutritional Management Results in Harm to CHDC Residents from Pressure Ulcers.

707. CHDC residents suffer from an unacceptably high rate of skin pressure ulcers/sores. CHDC's substantial departure from generally accepted professional standards requiring that direct care staff reposition residents in adherence with residents' prescribed positioning plans, that staff accurately document implementation of the positioning plans, and that CHDC professional staff adequately monitor and properly train direct care staff to implement the plans correctly, causes CHDC residents to suffer harm, and increased risk of harm, from pressures sores. *See* FOF ## 708-713.

708. Approximately 200 CHDC residents are at a high risk for pressure ulcers because of their diminished mobility and reliance on staff for repositioning. Crawford Tr. 2876:16-2877:8, 2878:15-18. Forty-six CHDC residents suffered 77 incidents of pressure sores from June 2007 through September 2009. Crawford Tr. 2874:23-2875:2; US Ex. 998. This rate is high compared to other similar facilities. Crawford Tr. 2875:17-19. Even a 14-18% rate of pressure sores is considered high by professional associations. Schmeler Tr. 3490:10-3491:3. Defendants' consultant testified that a facility should be expected to take steps to reduce such a high rate. Schmeler Tr. 3491:2-4.

709. Seventeen CHDC residents had multiple episodes of pressure ulcers during this same two-year period, each of whom were considered to be non-ambulatory and were seated in a wheelchair for their primary means of mobility. Crawford Tr. 2878:4-14.

710. CHDC staff fail to properly reposition residents to prevent pressure sores. Generally accepted minimum professional standards require staff to reposition non-ambulatory individuals who are dependent upon others for positioning at least every two hours for adequate pressure relief. Crawford Tr. 2880:5-12; Schmeler Tr. 3510:10-14. Most CHDC individual positioning plans contain identical recommendation for 2 to 3 periods of scheduled positioning per day of 30 to 45 minutes. Crawford Tr. 2884:2-11. The CHDC logs that document individuals' positioning, however, revealed that CHDC staff fail to reposition many residents in adherence to the residents' positioning plans and CHDC direct care staff are not implementing the positioning plans as written. Crawford Tr. 2886:19-2887:17. In addition, although residents' needs are not confined to weekdays, CHDC staff do not implement the positioning plans on the weekends. Crawford Tr. 2887:4-10. Defendants' consultant testified that a staff's failure to comply with repositioning plans would constitute a violation of generally accepted minimum professional standards. Schmeler Tr. 3510:21-3511:5.

711. For example, even though resident DB's positioning plan states that she should be in her wheelchair for extended periods of time throughout the day and have 2 to 3 periods of scheduled positioning per day of 30 to 45 minutes, the log indicated that she was in her wheelchair only 15 times during a 3 month period. Crawford Tr. 2891:7-15; US Ex. 994. DB suffered from pressure sores in October 2008 and July, August, and September 2009. Crawford Tr. 2891:24-2892:15. At least six other residents on DB's unit suffered similar harms from pressure sores.

Crawford Tr. 2893:10-18. A CHDC staff member in that unit admitted that staff only position the residents in their wheelchairs when the resident is going to class. Crawford Tr. 2894:8-14. To remedy this deficiency, generally accepted minimum professional standards require that CHDC properly train staff to ensure that they can implement the plans correctly and that CHDC adequate monitor staff so that errors can be caught and corrected. Crawford Tr. 2894:16-22.

712. In another case reviewed by Defendants' own consultant, discrepancies existed between therapy staff recommendations and the individual's actual treatment plan and treatment logs. Schmeler Tr. 3498:22-25. For instance, the therapy staff's annual report noted treatment recommendations that did not appear in the resident's positioning plan. Schmeler Tr. 3499:3-7. Defendants' consultant opined that such inconsistencies would be a substantial departure from generally accepted minimum professional standards. Schmeler Tr. 3499:8-11.

713. Generally accepted minimum professional standards require accurate documentation to demonstrate that staff are implementing the residents' positioning plans. Crawford Tr. 2896:5-8. The CHDC physical therapy supervisor, however, confirmed that the CHDC physical therapists do not review any of the positioning documentation logs to confirm that staff are implementing the residents' individual positioning plans. Crawford Tr. 2894:22-24. The physical therapy supervisor testified that no one at CHDC specifically confirms that each staff member is trained on the positioning plans of the residents with whom they work. L. Hancock Tr. 5299:10-13.

XIII. CONCLUSIONS OF LAW – PHYSICAL AND NUTRITIONAL MANAGEMENT

Defendants violate the Constitution with substandard physical and nutritional management services that subject residents to preventable harm from choking, aspiration

pneumonia, bone fractures, and skin pressure sores. The Fourteenth Amendment guarantees CHDC residents the right to therapeutic services, to help maintain or improve functions and to prevent harm from serious medical conditions. *See Youngberg*, 457 U.S. at 315, 324 (holding an institutionalized person has a constitutionally protected right to reasonable safety, rehabilitation, and adequate medical care). Defendants violate CHDC residents' right to adequate physical and nutritional management services if CHDC's administration of these services "substantial[ly] depart[s] from accepted professional judgment, practice, or standards." *Id.* at 322-23. CHDC must provide physical and nutritional management services by qualified and trained staff, both at a professional and direct care level. *See id.* at 323 n.30 (finding, even for day-to-day matters, that untrained staff should be supervised by a qualified professional).

Many CHDC residents have, or are at risk of developing, conditions such as airway obstructions, pneumonia, bone fractures, skin pressure sores, and other infections. CHDC's unlawful physical and nutrition management practices substantially depart from generally accepted minimum professional standards that require: (1) direct care staff to properly implement the residents' physical and nutritional management plans; (2) professional staff to monitor direct care staff implementation and effectiveness of the plans; (3) adequate, competency-based training; and (4) complete and timely responses to incidents. These substantial departures put CHDC residents at an unconstitutional risk of choking, aspiration pneumonia, bone fractures, and pressure sores.

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XIV. FINDINGS OF FACT – SPECIAL EDUCATION

714. The Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 *et seq.*, requires that every child with disabilities is provided a free appropriate public education ("FAPE"). To meet this obligation, the state must offer students special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living.[1] 20 U.S.C. § 1400(d); 34 C.F.R. §§ 300.1, 300.17.

715. IDEA was enacted because "[a]lmost 30 years of research and experience ha[d] demonstrated that the education of children with disabilities can be made more effective by having high expectations for such children and ensuring their access to the general education curriculum in the regular classroom, to the maximum extent possible." 20 U.S.C. § 1400(c)(5)(A).

716. CHDC's procedural and substantive violations of the IDEA deprive CHDC students of FAPE, as guaranteed by the IDEA. CHDC's violations result in: (1) students' continued isolation in the *most* restrictive educational environment, with unlawfully reduced instructional time; (2) cookie cutter individualized education programs ("IEPs"), that are not supported by adequate educational assessments and are not adequate to address students' academic and functional needs; (3) denial of access to communication and audiology services, psychological/behavioral services, and other related services students need to access and benefit

[1]Arkansas receives federal funding under Part B of the IDEA, 20 U.S.C. § 1400 *et seq.*, and thus is subject to the requirements of the IDEA and its implementing regulations, 34 C.F.R. pt. 300. Defs. Reply to Plaintiff's Proposed Findings of Fact at 1 (declining to contest the United States' Proposed Finding of Fact ¶ 173); Defs. Reply to Plaintiff's Statement of Undisputed Facts, ¶ 67 [Dkt. 104]. Even if any of the Defendants in this case did not receive federal funds, Arkansas special education regulations apply to any public agency that provides special education and related services to children with disabilities, regardless of whether that agency is receiving funds under Part B of the IDEA. Ark. Admin. Code § 1.02.2.2.

from educational services; (4) denial of access to adequate transition planning and services that would allow students to transition from post-secondary education to adult life; (5) exclusion of parties necessary at IEP meetings to ensure access to the general education curricula and the least restrictive educational setting; and (6) denial of access to statewide and districtwide assessments required for students to benefit from statewide academic content and achievement standards.

717. The United States' educational expert found these deficiencies, and, at the same time, the Arkansas Department of Education ("ADE") found IDEA non-compliance at CHDC. As the State's own investigators found violations in line with the United States' special education expert's findings, there is an independent basis for a finding of IDEA violations. 20 U.S.C. § 1401(9)(B).

A. Expert Susan Thibadeau Provided Credible Expert Testimony That CHDC's Education Program Violates Numerous IDEA Requirements.

718. Dr. Susan Thibadeau, the United States' special education expert, found numerous procedural and substantive IDEA violations, many of which ADE subsequently confirmed in its January 2010 on-site evaluation. Even the Defendants' special education consultants, Derek Nye and Dr. Bruce Gale, found deficiencies in some of the same areas where Dr. Thibadeau and ADE found IDEA violations. Gale Tr. 5748:19-5749:1, 5755:20-5756:10; Nye Tr. 5137:17-5138:20.

719. Dr. Susan Thibadeau is qualified as an expert witness in special education and psychological/behavioral services. She has a Ph.D. in developmental and child psychology and a master's degree in special education. She is a licensed psychologist in the State of Maine and Commonwealth of Massachusetts. She is a certified special education teacher in the

Commonwealth of Massachusetts and a board certified doctoral level behavior analyst.[2] Thibadeau Tr. 2171:1-19.

720. Dr. Thibadeau also has extensive experience educating children with developmental disabilities, including working as a psychologist, educator, and director of research and training at a state institution in Massachusetts for adults and children with disabilities; teaching children with significant disabilities; serving as director of community services and ultimately as program director in a non-profit program; teaching high school students with behavior disorders; providing educational consulting services to public schools; and teaching undergraduate- and graduate-level courses in special education and psychology. Thibadeau Tr. 2171:20-2173:8; US Ex. 1101-1.

721. Dr. Thibadeau has broad experience evaluating educational services, including completing assessments of entire school programs, and providing technical assistance regarding individual students' functional behavior assessments and behavior support plans. Thibadeau Tr. 2173:9-2174:2.

722. Dr. Thibadeau served as an expert witness for educational services in an institutional conditions case in federal court in Tennessee and currently serves on the monitoring team for a consent decree involving state institutions for individuals with developmental disabilities in Texas. Thibadeau Tr. 2173:24-2174:10.

723. Dr. Thibadeau's review of educational services at CHDC included on-site inspections in July and September 2009. Thibadeau Tr. 2183:22-2185:10. Dr. Thibadeau participated in a tour of the facility, including resident living units and day activity areas. She also conducted between six and nine classroom observations in each of the five CHDC classrooms, as well as

[2] Defendants' special education consultant, Derek Nye, has no formal training about the IDEA. Nye Tr. 5171:18-20.

observations of several habilitation training classes and the sheltered workshop. Thibadeau Tr. 2183:22-2185:24.

724. Dr. Thibadeau reviewed education-related documents for each of the 45 students who were then admitted as residents of CHDC (as opposing to being placed at CHDC on respite status). Among the documents were IEPs,[3] individual program plans ("IPPs"), behavior support plans, strategies for improving behavior, and safety plans. Thibadeau Tr. 2185:25-2186:9, 2171:1-11. She also interviewed four of the six CHDC classroom teachers, the special education director, and the two teaching supervisors; participated in interviews of the lead psychological examiner, a second psychological examiner, the psychiatrist, and the director of nursing; and attended the depositions of teachers Susan Milum and Throndia Smith and special education director Tamara Hill. Thibadeau Tr. 2171:1-11, 2184:15-2185:10.

B. Arkansas's State Educational Agency Issued Numerous Findings of IDEA Non-Compliance at CHDC for This Monitoring Period.

725. Under the IDEA, FAPE is not provided unless students' special education and related services "meet the standards of the State educational agency." 20 U.S.C. § 1401(9)(B). Arkansas standards for the provision of special education and related services incorporate federal IDEA implementing regulations, as set forth in 34 C.F.R. § 300 *et seq.*, and any additional requirements imposed by the State Educational Agency ("SEA") or state law. *See generally* Ark. Admin. Code § 005.18.2.

726. ADE is the SEA "responsible for ensuring that the requirements of this subchapter are met." 20 U.S.C. § 1412(a)(11)(A)(i); Ark. Admin. Code § 005.18.2-2.03; Harding Tr. 3000:7-

[3] An IEP is the required written statement for each child with a disability that sets forth the comprehensive educational services that are to be provided to the student annually, including special education services, related services, and transition services. 20 U.S.C. § 1401(14), 1414(d).

11; Defs. Reply to Plaintiff's Proposed Findings of Fact at 1 (declining to contest the United States' Proposed Finding of Fact ¶ 174).

727. ADE recently cited CHDC for failing to provide students with FAPE in accordance with the IDEA, based on 15 enumerated areas of non-compliance. Thibadeau Tr. 2203:11-2204:21; Harding Tr. 2988:7-2989:5, 3006:23-3007:6, 3008:20-24; US Ex. 1104. ADE's findings are largely consistent with Dr. Thibadeau's findings.[4] Thibadeau Tr. 2204:7-21.

728. On June 16, 2010, ADE sent CHDC a letter reporting the results of ADE's January 2010 official site monitoring visit assessing CHDC's compliance with federal and state special education laws and regulations ("ADE report"). This letter detailed 15 areas where CHDC failed to comply with state and federal law and regulations. Thibadeau Tr. 2203:11-2204:21; Harding Tr. 2988:7-2989:5, 3006:23-3007:6, 3008:20-24; US Ex. 1104.

729. ADE employed a method of review similar to that used by Dr. Thibadeau: review of a sample of student records, interviews with CHDC staff, and classroom observations. Harding Tr. 2989:23-2990:4, 3026:19-3032:12.

730. ADE issued four findings of non-compliance regarding CHDC's IEPs, including: (1) CHDC fails to consider special factors impeding students' learning when developing student IEPs; (2) IEP components do not address the unique needs of individual students; (3) CHDC transition plans are not based on age appropriate transition assessments and do not describe appropriate measurable post-secondary goals; and (4) CHDC does not inform parents of student progress toward meeting annual goals and short term objectives on a quarterly basis. Harding Tr. 3000:3-3006:22; US Ex. 1104.

[4] ADE's report addressed substantially the same topics as Dr. Thibadeau's Rule 26 report in this case. Thibadeau Tr. 2211:7-22.

731. ADE also found that CHDC meets neither teacher/pupil ratios nor IDEA-required deadlines for completing comprehensive disability evaluations, reevaluations, written reports, and student eligibility conferences. Harding Tr. 2995:4-24, 2998:16-3000:2, 3008:25-3010:20; US Ex. 1104.

732. ADE found that CHDC educational services fail to address all of students' identified special education and related services needs. Harding Tr. 3000:3-19, 3007:7-3008:19; US Ex. 1104.

733. Participation of outside agencies is essential to facilitate students' transition to appropriate postsecondary settings. Thibadeau Tr. 2299:20-2300:21. ADE found that CHDC was not inviting outside agencies to participate in CHDC IEP meetings about transition services, in violation of the IDEA. Harding Tr. 2990:22-2991:12; US Exs. 1104 & 1201. Moreover, even when appropriate agencies were identified, they were unable to participate in the IEP meetings because CHDC failed to notify parents and request parental consent for their participation, as required by the IDEA. Thibadeau Tr. 2181:22-2182:13, 2300:22-2301:19; US Exs. 1104 & 1201.

734. ADE cited CHDC for failing to provide clinical justification for the shortened school days provided to all CHDC students. Harding Tr. 3011:23-3013:10; US Ex. 1104.

735. ADE also cited CHDC for inadequate teacher training, including insufficient evidence of the use of promising educational practices in special education instruction. Harding Tr. 3015:17-3018:25; US Ex. 1104.

C. CHDC IEP Teams Do Not Include All Members Required by the IDEA.

736. The IDEA requires that certain categories of educational staff participate in IEP team meetings. 20 U.S.C. § 1414(d)(1)(B). CHDC fails to include all of the IDEA-required team

members in its IEP meetings. CHDC routinely fails to ensure that representatives from the local education agency ("LEA") and regular education teachers from the students' home schools participate in IEP meetings. Thibadeau Tr. 2213:2-2214:15, 2217:11-16, 2220:16-2221:13; Gale Tr. 5748:19-5749:1; US Ex. 1105; Defs. Response to Plaintiff's Statement of Undisputed Facts ¶ 69 [Dkt. 104].

737. IEP teams must determine the least restrictive environment appropriate for students in order to maximize their opportunities to interact with their non-disabled peers. A representative from the LEA needs to attend CHDC IEP team meetings so that the team can adequately discuss possible less restrictive alternatives with representatives of students' home school districts.[5] Thibadeau Tr. 2213:5-2214:9.

738. Where a less restrictive alternative is appropriate and a student could attend classes with his non-disabled peers at his home school, a regular education teacher must also participate in the IEP meeting. 20 U.S.C. § 1414(d)(1)(B); Thibadeau Tr. 2417:14-24; US Ex. 1105.

739. Defendants' special education consultant Dr. Bruce Gale characterized the lack of LEA participation at CHDC IEP meetings as "an enormous problem." Gale Tr. 5748:19-5749:1.

740. CHDC education documents provide no indication that parents or guardians have consented to the absence of LEA representatives or regular education teachers, which is required by the IDEA for absent team members, as well as prior written input into the development of the IEP prior to the meeting. 20 U.S.C. § 1414(d)(1)(C); Thibadeau Tr. 2220:6-15.

[5] Although CHDC IEPs sometimes list a CHDC staff employee as the LEA representative, *see* Thibadeau Tr. 2219:13-2220:5; US Exs. 1107, 1108, 1201, a CHDC employee cannot fulfill this function, as CHDC is not a school district and, in any event, the staff person does not fulfill the statutory requirements of an LEA representative. *See* 20 U.S.C. § 1414(d)(1)(B).

D. CHDC's Special Education Instructional Time Is Inadequate.

741. CHDC is the most restrictive type of educational environment along the IDEA's continuum of placements, as it affords CHDC students no regular interaction with their non-disabled peers. Thibadeau Tr. 2176:10-25.

742. CHDC students have significant academic and functional skill needs, including needs for development of communication, socialization, self-care, domestic, and leisure skills. Thibadeau Tr. 2177:16-2178:2. Instructional time must be adequate to meet students' academic and functional needs. Thibadeau Tr. 2176:10-2178:2.

743. All CHDC students receive a shortened school day and spend an inadequate amount of time in special education classes. Thibadeau Tr. 2176:10-25, 2205:3-2206:9; US Exs. 1201 & 1208. No CHDC student attends school for a full day. More specifically, 65% of the 45 CHDC students reviewed by Dr. Thibadeau have spent only 450 minutes per week, or 1.5 hours per day, in special education classes, even though the school day is supposed to last from 9 am until 3:30 pm, or approximately 6.5 hours, as in a typical school. Thibadeau Tr. 2186:23-2187:21, 2194:6-2196:10. This is entirely inadequate to satisfy CHDC students' significant academic and functional skill needs and facilitate their transition to a less restrictive educational placement. Thibadeau Tr. 2176:10-25.

744. The United States' special education expert's document review revealed that the maximum amount of special education instruction provided by CHDC for a student is 2.5 hours per day – and only 1 student spent even this length of time in school. Thibadeau Tr. 2188:11-21; US Ex. 1102.

745. ADE's findings regarding the time CHDC students spend in special education were consistent with Dr. Thibadeau's findings. Thibadeau Tr. 2210:3-13; US Exs. 1209 & 1210.

746. Defendants have admitted that CHDC school-aged youth spend no more than half of their school day in a classroom with special education certified teachers. Thibadeau Tr. 2221:14-22; US Ex. 1105 at 4.

747. CHDC's special education coordinator, who is not certified in special education, separately admitted to Defendants' special education consultant that she pre-determines that new school-aged admissions to CHDC do not need (and will not receive) a full-time education program. Nye Tr. at 5146:6-5147:9, 5189:16-5193:4; US Ex. DN-1.

748. Even when CHDC attempted in summer 2010 to increase the number of minutes some students spend in special education classes, CHDC did not increase the number or complexity of IEP objectives; accordingly, the special education instruction CHDC provides remains inadequate. Thibadeau Tr. 2194:6-2195:19; US Ex. 2026 at US-CON-E-0031312-414 (IEPs of CW, SW, JB, WR, JM, CT, NS, and BR, as modified in summer 2010).

749. Contrary to the practice at CHDC, children with disabilities generally should attend classes for just as long as their peers without disabilities. Thibadeau Tr. 2195:20-2196:23. Special education teachers commonly use strategies to help students attend to tasks and address behaviors so they can learn in the classroom. Thibadeau Tr. 2196:24-2197:17. Indeed, the IDEA requires that "in the case of a child whose behavior impedes the child's learning and that of others, [the IEP team] consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior." 20 U.S.C. § 1414(d)(3)(B)(i).

750. Shortening students' school days for supervision, personal care, or behavioral needs is inappropriate because these needs call for a more intensive special education services, not a shorter school day. Thibadeau Tr. 2198:17-2199:1. Shortening class time to address students'

inappropriate behaviors or problems with focusing on tasks also violates the IDEA. Thibadeau Tr. 2195:20-2197:17, 2200:8-2201:5, 2206:10-24.

751. ADE also found that CHDC students were not attending class for a full day, and CHDC IEPs did not adequately substantiate why students had these shortened school days. Thibadeau Tr. 2205:3-2206:24, 2349:8-2350:6; Harding Tr. 3011:163-3013:10; US Exs. 1104, 1201, 1208 & 1216.

752. ADE also found IDEA violations based on the absence of documentation of periodic evaluations to measure progress and failure to implement behavior support plans to increase students' time in the educational setting. Thibadeau Tr. 2279:9-19; US Ex. 1214. Further, ADE found that students whose reduced school schedules were reportedly a consequence of their being unable to focus for long periods of time nonetheless had full day schedules of activities, suggesting that the reported reason for shortened school days was not valid. Thibadeau Tr. 2279:20-2280:21.

753. In their prior public school placements, CHDC students attended special education classes for exponentially more time than they attend special education classes at CHDC. Thibadeau Tr. 2210:15-2211:6; US Exs. 1102, 1103-1 through 1103-9 & 1214.

754. ADE also noted that students such as JB had a much more intensive schedule in prior placements. For example, JB went from attending 1800 minutes of instruction in social skills, self-help, language arts, functional reading and math each week at his prior placement to 450 minutes of special education every week at CHDC. Thibadeau Tr. 2346:8-16; US Ex. 1216.

755. CHDC schedules students for an hour and a half of lunch, leisure, and personal grooming, but does not include active programming for the development of communication or leisure skills in students' schedules. This deficiency is significant because many CHDC students

have limited communication and social interaction skills, which are not being adequately developed during the limited classroom time or outside the classroom at CHDC. Thibadeau Tr. 2188:21-2191:15.

756. CHDC educators do not adequately generalize skills so students can apply them outside the classroom setting, as demonstrated by the common method of teaching money management through fake coins and not applying money management in real-world situations, such as at the canteen. Thibadeau Tr. 2191:16-2192:24.

757. The amount of time CHDC students spend in transition from special education classes to other activities also reduces CHDC students' limited time in class, as it results in students arriving late or leaving early. Thibadeau Tr. 2197:19-2198:16, 2413:22-2414:5. ADE also observed discrepancies between the limited time scheduled for special education classes and the even smaller amount of time CHDC students actually spend in class. Thibadeau Tr. 2211:23-2212:21; US Ex. 1214.

758. CHDC students spend a significant amount of their day in habilitation classes taught by instructors who have no special education certification or any teaching certification. Thibadeau Tr. 2221:23-2222:6; Smith Tr. 2155:3-8; Buck Tr. 6536:17-19; Price 1660:23-1661:4; US Ex. 1105 at 4. These habilitation instructors are not supervised by special education certified teachers, as they should be if they are to be providing special education instruction. Thibadeau Tr. 2192:25-2193:2194:5; Nye Tr. 5177:8-5178:2 (habilitation classes are not part of CHDC's special education program).

759. CHDC school-aged students may attend habilitation classes during the school day with adults, Smith Tr. 2156:1-3, which is not a normalizing experience for these students.

Defendants' special education consultant, Derek Nye, found that a typical ratio of school-aged students to adults in CHDC habilitation classes is 1 student to 5 adults. Nye Tr. 5176:23-5177:7.

760. Relying on non-special education certified individuals to teach habilitation skills deprives CHDC students of the benefits of special education instruction. Teaching students who require special education instruction requires specific skills, such as the ability to break tasks into small steps, shape skills, chain activities together to form a more complex skill, use prompting strategies (and planning for the effective fading of those prompting strategies), and identify and apply reinforcers. Thibadeau Tr. 2192:25-2194:5.

761. The IDEA requires that students with disabilities continue to receive FAPE even when they are suspended or placed in an interim setting, where that removal is for longer than ten days. 20 U.S.C. § 1415(k). CHDC, however, further shortens students' instructional time by restricting students to their residences as punishment for behavior problems, without input from the education program. Thibadeau Tr. 2199:2-8; Milum Tr. 2122:17-2123:4.

762. CHDC employs a Special Treatment Unit Levels of Reinforcement System, which inappropriately conditions attendance in school on students' behavior by including "going to class" on the Menu of Reinforcers. This program withholds education from students, including in situations where there is no current concern that a student's behavior would place himself or others at risk of harm. Thibadeau Tr. 2199:9-2200:7, 2353:6-2354:7 (system continues in 2010 IEPs); US Ex. 2026 at US-CON-E-0031249, US-CON-E-0031265 (examples of ongoing use in students' IEPs). Even Defendants' psychology consultant is concerned with this program. Walsh Tr. 6111:6-13.

763. Defendants' special education consultant, Derek Nye, testified that it will take a long time for CHDC to hire sufficient numbers of certified staff to provide students with an

appropriate amount of special education instructional time in classes that meet ADE-required teacher to student ratios. Nye Tr. 5167:23-5168:20.

E. CHDC IEP Goals and Objectives Fail To Meet IDEA Requirements.

764. The IDEA prescribes specific requirements for IEP goals and objectives, including the requirement that they address both academic and functional areas impacted by a student's disability. 20 U.S.C. § 1414(d). Students with significant needs should receive training in academic, communication, social, self-care, leisure, vocational, domestic, and community skills. Thibadeau Tr. 2177:16-2178:2, 2222:12-2223:5, 2415:21-2416:12.

765. CHDC students' IEP annual goals and short-term objectives do not provide for comprehensive education to meet the full range of student needs; rather, CHDC student IEPs focus solely on academic skills and exclude functional skills such as communication, social, self-care, leisure, vocational, domestic, and community skills.[6] Thibadeau Tr. 2177:16-2178:2; US Exs. 1109 through 1114 (examples of illustrative inadequate IEP goals and objectives for CHDC students SA, TF, BH, JM, TS, CT).

766. ADE also criticized CHDC for limiting its IEP development to academic goals. Harding Tr. 3022:3-22; US Ex. 1186.

767. CHDC IEPs also contain insufficient numbers of goals and objectives. Though each IEP must include goals "designed to (aa) meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum; and (bb) meet each of the child's other educational needs that result from the child's disability," 20 U.S.C. § 1414(d)(1)(A)(i)(II), some IEPs only include two objectives for an entire year. Other

[6] The IDEA requires that each student's IEP contain "a statement of measurable annual goals, *including academic and functional goals*." 20 U.S.C. § 1414(d)(1)(A)(i)(II) (emphasis added); *see also* 34 C.F.R. § 300.320(a)(2).

IEPs include only four objectives, two of which begin to be taught only after the other two are completed. Thibadeau Tr. 2177:16-2178:2; Smith Tr. 2161:21-2162:2.

768. Where an IEP identifies a skill that a student should master, the IEP's short term objectives should include: (1) a statement indicating conditions under which the new skill will be performed; (2) a description of the skill in observable and measurable terms that allow teachers to determine whether it has been mastered; and (3) a plan for maintenance and generalization of the skill. 20 U.S.C. § 1414(d); Thibadeau Tr. 2223:6-14.

769. CHDC students' IEP objectives do not meet these standards because, by failing to indicate the number of trials or sessions during which the student must demonstrate a certain level of performance, the IEPs fail to indicate the mastery criteria for the observable behavior the student is to exhibit. CHDC IEPs also lack evidence of planning for skill maintenance and generalization. Thibadeau Tr. 2178:3-12, 2223:15-2237:21; US Exs. 1109 through 1114 (examples of illustrative inadequate IEP goals and objectives for CHDC students SA, TF, BH, JM, TS, CT).

770. The IDEA requires that IEPs contain observable and measurable goals so, to the extent this information is contained in other documents outside the IEP, such as in an IPP, this would not satisfy the IDEA. Thibadeau Tr. 2238:1-9, 2415:3-9.

771. Consistent with Dr. Thibadeau's opinion, ADE also found that in many cases, CHDC IEP goals and objectives are poorly written, and the objectives often do not relate to the goals or address the specific needs of the student. Thibadeau Tr. 2239:2-2240:5; US Ex. 1214. For example, ADE found that student BM's IEP contained the same objectives two years in a row, and those objectives only addressed the use of a wheelchair. Thibadeau Tr. 2344:17-2345:11; US Ex. 1216. ADE also found that student CA's IEP goals and objectives had little connection

to each other and to CA's needs, as the student had a two year-old functional speech level and could only say a few words but was supposed to be "learning the language of algebra." Thibadeau Tr. 2345:12-2346:3; US Ex. 1216.

772. Defendants' special education consultant, Derek Nye, concurs with Dr. Thibadeau that at least some CHDC IEP objectives are not clear, particularly with regard to the conditions under which tasks were to be performed. Nye Tr. 5159:5-24. Mr. Nye acknowledges that CHDC education staff would benefit from training regarding the writing of IEP goals and objectives. Nye Tr. 5160:3-14.

773. Defendants' other special education consultant, Dr. Bruce Gale, testified that goal writing appears to be the biggest problem with CHDC IEPs. Gale Tr. 5748:5-12.

774. Teachers do not consistently use objective measures to assess progress toward even those goals and objectives that are included on the IEPs. Thibadeau Tr. 2287:5-2289:6.

775. Also consistent with Dr. Thibadeau's observations, ADE found that some teachers and aides did not consistently chart student progress, and it was unclear how progress was measured other than correct versus incorrect answers. Thibadeau Tr. 2289:7-19; US Ex. 1214.

F. CHDC Fails To Administer IDEA-Required Statewide and Districtwide Assessments.

776. The IDEA, in addition to the No Child Left Behind Act, requires that students with disabilities participate in statewide assessments to the same extent as their non-disabled peers – by participating in: (1) general statewide assessments without accommodations; (2) general statewide assessments with accommodations; or (3) alternate assessments. *See* 20 U.S.C. § 1412(a)(16) (requiring that "[a]ll children with disabilities are included in all general state and districtwide assessment programs, including assessments described under section 6311 of this

title, with appropriate accommodations and alternate assessments where necessary and as indicated in their respective individualized education programs.").

777. IDEA-required statewide and districtwide assessments ensure that students with disabilities have access to the State's challenging academic content standards and that the State measures the achievement of children with disabilities against those standards. *Id.*; Thibadeau Tr. 2248:23-2250:10. CHDC IEPs do not indicate a grade level and students do not receive grades as they do in the public schools, *see, e.g.,* US Ex. 2026 (updated CHDC IEPs), so statewide and districtwide assessments are especially important for measuring student progress.

778. CHDC is not exempt from any IDEA or ADE requirements. Harding Tr. 2990:5-7. ADE has only advised CHDC that it is exempt from statewide and districtwide assessments under the No Child Left Behind Act; ADE has not provided CHDC with any opinion regarding whether the IDEA also requires statewide and districtwide assessments. Harding Tr. 3057:5-14.

779. Defendants' special education consultant agrees that both the IDEA and the No Child Left Behind Act require statewide and districtwide assessments, so, even if CHDC were exempt under the No Child Left Behind Act, the IDEA would nevertheless require such assessments. Nye Tr. 5195:4-8.

780. CHDC students do not participate in: (1) general statewide or districtwide assessments without accommodations; (2) general statewide or districtwide assessments with accommodations; or (3) alternative assessments, *i.e.*, the Arkansas Alternative Assessment Program. Thibadeau Tr. 2248:23-2249:24, 2250:11-22, 2251:6-25; Milum Tr. 2141:7-12; Smith Tr. 2164:4-9; Defs. Response to Plaintiff's Statement of Undisputed Facts ¶ 73 [Dkt. 104]; US Ex. 1214.

G. CHDC Fails To Consider IDEA-Required Factors in Developing Students' IEPs.

781. The IDEA prescribes certain required factors that IEP teams must consider in developing students' IEPs, including students' academic, developmental, functional, and communication needs. 34 C.F.R. § 300.324(a).

782. CHDC assessment tools do not address all necessary areas of development to enable accurate assessment of present levels of performance and appropriate development of goals and objectives. Thibadeau Tr. 2177:1-15.

783. CHDC relies heavily on Brigance assessments, which do not assess functional skill development in areas such as communication, self-help, domestic, leisure, and vocational skills; skill development in these areas is particularly important for older students. CHDC also relies heavily on the Brigance Diagnostic Inventory for Early Development, an assessment tool intended for use with children from birth to age seven, which does not result in age-appropriate goals and objectives for many CHDC students and fails to address important life skills, goals, and objectives. Thibadeau Tr. 2177:1-15, 2241:4-2243:16; Smith Tr. 2164:1-3 (CHDC tries to use Brigance assessment to measure functional skills).

784. CHDC does not conduct comprehensive teacher-made assessments to address the areas of need omitted by the formal educational assessment inappropriately relied upon by CHDC, the Brigance. Thibadeau Tr. 2243:25-2245:10.

785. ADE also criticized CHDC for relying heavily on the Brigance Inventory for Early Development and for not using educational assessments that measure functional outcomes. Harding Tr. 3022:3-22; US Ex. 1186. Accordingly, ADE recommended in 2005 that CHDC replace the Brigance with an updated formative evaluation tool to better assess student strengths and needs. US Ex. 1186 at 4.

786. CHDC does not train its teachers on administering the formal assessments they give to CHDC students, including the Brigance and reading-free vocational assessment. Milum Tr. 2135:4-8.

787. The IDEA also requires that assessments be administered in a manner that meets the communication style of the individual who is being assessed. 34 C.F.R. § 300.324(a)(2). CHDC has not met this obligation because it has not offered these assessment accommodations to all students with disabilities. For example, a student with a visual impairment did not receive an assessment because it was typically offered in pictoral form, and a student with a hearing impairment did not receive a different assessment because a sign language interpreter was not available. Thibadeau Tr. 2246:14-2248:20; US Exs. 1193 & 1229.

H. CHDC Fails To Provide Related Services to All Students Who Require Them To Benefit from Special Education Services.

788. FAPE under the IDEA requires provision of all related services required by students' needs. 20 U.S.C. §§ 1412, 1401(a)(18). "Related services" includes "transportation, and such developmental, corrective, and other supportive services (including speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, school nurse services . . . counseling services, including rehabilitation counseling, orientation and mobility services, and medical services . . .) as may be required to assist a child with a disability to benefit from special education." 20 U.S.C. § 1401(a)(26). Related services are essential to ensuring that students are able to access and benefit from education. *Id.*; 34 C.F.R. § 300.34; Thibadeau Tr. 2252:1-13.

789. CHDC fails to provide related services, including speech services, communication device implementation, psychological/behavioral services, and sign language interpretative services, to all students who require them. Thibadeau Tr.2252:1-2253:6.

790. ADE also found that CHDC does not provide all of the services needed to meet students' identified special education and related services needs. Harding Tr. 3000:3-19; US Ex. 1104.

791. Consistent with Dr. Thibadeau's observations, ADE found numerous examples of CHDC students whose education files indicated they were not receiving all required related services, such as communication and behavioral/mental health services, including students BR, BB, KF, CW, and MB. Thibadeau Tr. 2340:24-2344:16, 2346:4-7, 2347:5-2348:24; US Ex. 1216.

792. The IDEA requires that, if a student's behavior or other special factor impacts his or her learning, the student's IEP address that need. Harding Tr. 3001:4-3002:10. Among the steps that the IEP team must take where a child's behavioral needs are affecting his or her learning are the consideration of positive behavioral supports and interventions. 20 U.S.C. § 1414(d)(3)(B)(i).

793. On their face, CHDC IEPs indicate that students should be receiving related services, such as behavioral services and communication services, yet the IEPs do not list any such services being provided. Buck Tr. 6543:21-6544:13, 6545:5-6546:5; US Ex. 2026 at US-CON-E-0031229, US-CON-E-0031263, US-CON-E-0031313 (updated IEPs showing that Defendants continue to fail to remedy related services deficiencies).

794. Though a significant percentage of youth at CHDC were admitted in part because of behavioral problems, CHDC does not offer any counseling or psychotherapy services. Nye Tr. 5222:2-5; *see also* A. Green Tr. 846:9-17 (majority of CHDC children are admitted because they have significant behavioral health needs).

795. CHDC fails to integrate related services with other CHDC services, resulting in additional gaps in services for students and insufficient information sharing among educational staff regarding the efficacy of the services in place. Thibadeau Tr. 2179:3-14, 2253:7-2255:6, 2276:13-17.

796. IDEA requires that the IEP team meet and revise an IEP to respond to, among other things, "any lack of expected progress toward the annual goals and in the general education curriculum, where appropriate." 20 U.S.C. § 1414(d)(4)(A)(ii)(I). However, the team process envisioned by the IDEA is not occurring at CHDC, as CHDC fails to ensure regular interaction between education and communications, physical therapy, and occupational therapy staff. Milum Tr. 2120:7-16; Smith Tr. 2166:20-2167:24. Education staff also do not interact regularly with psychology staff; rather, they interact only at annual meetings, upon a new student's arrival, and upon request. Milum Tr. 2119:18-2120:6. Psychology staff do not routinely come into CHDC classrooms without a teacher's request. Milum Tr. 2148:12-14.

797. ADE also found that CHDC psychology staff lack knowledge regarding the requirements of the IDEA and its implications in the education program. Harding Tr. 2996:24-2998:15; US Ex. 1199.

798. Consistent with Dr. Thibadeau's observations, ADE found little to no communication between education staff, related services staff, and residence staff, which is not surprising given that CHDC education staff schedules do not include time to communicate regarding students' needs. Thibadeau Tr. 2275:17-2276:12, 2278:8-18; US Ex. 1214. Generally, information is shared among disciplines only once a year at the IPP and IEP meeting. Milum Tr. 2119:9-20. This lack of communication precludes implementation of comprehensive service plans and undermines the integrity of plan implementation. Thibadeau Tr. 2278:19-2279:8.

799. Even Defendants' special education consultant, Derek Nye, testified that one of the teachers he interviewed felt that CHDC psychology staff are too busy, are located too far away, and are not meeting students' needs. Nye Tr. 5127:1-5128:1.

800. Defendants' other special education consultant, Dr. Bruce Gale, commented that the level of collaboration between psychological and speech staff could be better than it is. Gale Tr. 5742:12-5744:2.

801. CHDC related services staff also lack training in special education, and education staff lack training in related services. Thibadeau Tr. 2276:18-2277:6; US Ex. 1214. When ADE provided training to CHDC psychology staff regarding their IDEA obligations in July 2010, staff indicated a lack of understanding regarding their responsibilities and appeared to be under the mistaken impression that they were only charged with meeting ICF/MR CMS funding standards. Thibadeau Tr. 2281:16-2282:17; US Ex. 1199. As a result, CHDC students do not receive comprehensive related services. Thibadeau Tr. 2277:7-13.

1. CHDC Does Not Provide Adequate Communication/Audiology Services to Students.

802. All students who require communication skills development are entitled to and should be receiving such related services; otherwise, these students are not receiving FAPE. 20 U.S.C. §§ 1412, 1401(a)(18); Thibadeau Tr. 2259:23-2260:3. Both Dr. Thibadeau and ADE found a number of CHDC students who should be receiving communication services but are not. Thibadeau Tr. 2178:13-2179:2, 2255:7-23; US Ex. 1216 at US-CON-E-0049596 through 597.

803. CHDC utilizes a direct therapy method of speech language therapy, which results in students learning communication skills in only one environment, without learning to apply

communication skills outside the therapy room.[7] Thibadeau Tr. 2259:3-22. Defendants' consultant who commented on related services, Dr. Bruce Gale, suggested that CHDC consider using an integrated or consultative model instead of a direct therapy model of communication services. Gale Tr. 5738:2-10.

804. CHDC only offers its direct therapy model speech services to about half of the CHDC students who need them. Thibadeau Tr. 2178:13-2179:2, 2255:7-23.

805. CHDC inappropriately selects students for speech and language services according to the student's potential for progress and the student's interest in developing his/her skills. Thibadeau Tr. 2257:17-2258:5, 2259:23-2260:10.

806. Development of communication skills is especially important for children who engage in problem behavior, as it enables them to communicate in a manner other than through the problem behavior. Given that many children have been placed at CHDC for behavioral reasons, communication skill development should be paramount. Thibadeau Tr. 2256:5-2257:16.

807. Only 7 of the 21 non-verbal school-aged children at CHDC have augmentative communication devices. Johnson Tr. 5389:7-11. For this small number of CHDC students provided assistive technology, CHDC staff does not encourage the use of these devices and, consequently, students do not consistently use them. Thibadeau Tr. 2258:6-2259:2.

808. ADE also found instances of CHDC students not having access in the classroom to their alternative or augmentative communication devices, such as communication books or other communication devices. Thibadeau Tr. 2260:11-24, 2261:13-2262:23, 2350:25-2351:8; US Exs. 1201 & 1206.

[7] Speech/language therapists do not routinely go into classrooms to observe and assist with students' communication skills, further exacerbating the problem with transferring communication skills outside the therapy room using a direct therapy model. Thibadeau Tr. 2259:3-22.

809. The IDEA requires that hearing aids worn in school by students with hearing impairments are functioning properly. 34 C.F.R. § 300.113(a). ADE found that CHDC had not been regularly monitoring students' hearing aids in the classroom to ensure they were functioning properly. Thibadeau Tr. 2260:11-2261:12; US Ex. 1201. As a result, CHDC students, such as students LW, JB, and BB, have not had their required hearing devices available and functioning in the classroom, in violation of the IDEA. Thibadeau Tr. 2263:3-23, 2264:11-2265:14; US Exs. 1214, 1224 & 1225.

810. ADE also found no evidence of follow-up regarding poor vision and hearing and no evidence of formal augmentative alternative communication assessments in CHDC education files. Thibadeau Tr. 226324-2264:10; US Ex. 1211.

2. CHDC Does Not Provide Adequate Psychology/Behavioral Services to Students.

811. The IDEA requires that "in the case of a child whose behavior impedes the child's learning and that of others, [the IEP team] consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior." 20 U.S.C. § 1414(d)(3)(B)(i). In practical terms, this means that a functional behavior assessment and behavior support plan must be completed for students whose behavior results in their being placed outside of their regular education classrooms. Thibadeau Tr. 2271:23-2272:12.

812. According to CHDC IEPs, many CHDC students were placed at CHDC because of their behaviors. Thibadeau Tr. 2272:13-21; A. Green Tr. 846:9-17. Yet CHDC does not use functional behavior assessments with all CHDC students and, to the extent CHDC attempts to use functional behavioral assessments, they are not comprehensive in scope because, for example, they do not involve individuals like teachers who interact on a daily basis with the students. Thibadeau Tr. 2269:25-2270:12, 2271:9-22.

813. Consistent with Dr. Thibadeau's observations, ADE also noted that in most cases, students' education files do not include behavior plans or goals and objectives to address behavior in the education setting. Thibadeau Tr. 2277:23-2278:7; US Ex. 1214. ADE also found that CHDC did not necessarily address problem behaviors in the classroom for students who were on shortened school days reportedly for behavior issues. Thibadeau Tr. 2279:9-19; Harding Tr. 3011:23-3013:10; US Ex. 1214.

814. ADE found in its review of a sample of 15 students that at least 7 students who should have had behavior plans or strategies in their education files did not. Thibadeau Tr. 2273:9-24; US Ex. 1211. Accordingly, education staff cannot follow students' behavior plans, and those plans cannot be consistently implemented across students' environments. Thibadeau Tr. 2273:25-2274:8.

815. CHDC also fails to adequately train staff in plans for behavior interventions, as psychological examiners infrequently interact with teachers. Thibadeau Tr. 2266:24-2267:12, 2270:13-23, 2272:22-2273:8. ADE also found that some teachers knew little about behavior strategies for specific students, again affecting the consistency of implementation of behavior plans and strategies. Thibadeau 2277:14-22; US Ex. 1214.

816. Generally accepted professional standards require collecting and graphing daily measures of student performance, *i.e.*, an accurate measure of treatment integrity. CHDC's behavior reports are inaccurate measures of behavior because they do not define the target behaviors and offer ranges of behavior occurrences to assess, and, in any event, are inconsistently completed by CHDC staff. Thibadeau Tr. 2270:24-2271:8, 2286:6-2287:4, 2289:20-2291:14.

817. For example, Dr. Thibadeau witnessed two CHDC students engaged in self-harm that, per CHDC policy, should have triggered staff completion of behavior reports. Yet, upon Dr.

Thibadeau's request to see the behavior reports, the facility responded that for at least one of the incidents, no behavior report existed. Thibadeau Tr. 2179:3-2180:1.

818. Similarly, Defendants' special education consultant, Derek Nye, could not locate a behavior report for an incident he observed in which a student exhibited behaviors, was escorted out of class, and did not return. Nye Tr. 5224:17-5225:2.

819. ADE also criticized CHDC for its inadequate method of tracking behaviors by relying on teachers to count and record the numbers of observed behaviors. Harding Tr. 3025:2-10; US Ex. 1186 at 7.

820. Accurate behavior data is important because potential changes to behavior plans and medication tapers are based on such data. Thibadeau Tr. 2179:15-2180:13, 2291:15-2292:5.

821. The effects of inadequate behavior management tools also may be seen in CHDC's use of antiquated and inappropriate mechanical restraints on children. Numerous states, including Massachusetts and Maine, have outlawed mechanical restraints for children, yet CHDC continues to use a highly restrictive papoose board on children. Thibadeau Tr. 2284:25-2286:5.

822. Use of papoose boards in classrooms is doubly problematic because CHDC education staff admit that the restraints distract the class. Milum Tr. 2141:13-2142:10, 2147:11-21.

I. CHDC's Transition Planning and Transition Services Do Not Satisfy IDEA Requirements.

823. The IDEA requires that, once a student with disabilities turns 16 years old, schools provide a coordinated set of services to support the student as he or she moves from secondary education to post-secondary life, including vocational training, independent living skills, and supported employment. 34 C.F.R. § 300.320(b); Thibadeau Tr. 2292:6-18. Transition services for CHDC students do not address the needs of students who are 16 years or older; as a result,

students are not adequately prepared for vocational or post-secondary activities. Thibadeau Tr. 2292:6-2293:8.

824. IEPs must contain appropriate, measurable transition goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills and the transition services needed to reach these goals. 34 C.F.R. § 300.320(b). CHDC students' IEPs do not contain appropriate, measurable goals for transition services because CHDC students' transition plans do not clearly specify what skills the student is learning or how student performance will be measured. Thibadeau Tr. 2181:22-2182:7; Buck Tr. 6542:3-25; US Exs. 1115 through 1118.

825. Even Defendants' special education consultant, Derek Nye, found that CHDC transition plans lack clarity and fail to contain measurable goals, as required by the IDEA. Nye Tr. 5137:17-5138:20.

826. Several illustrative examples demonstrate how CHDC IEP transition goals are neither measurable nor appropriate. Thibadeau Tr. 2294:1-2298:10. For example, student JB's transition plan does not contain appropriate individualized, measurable goals but rather states that JB will identify community signs and write his first and last name - skills that may be supplemental to vocational skills but will not enable such skills. Thibadeau Tr. 2294:1-24; US Ex. 1115. Regarding independent living skills, student JB's IEP indicates only that he will identify health care items, which will not provide adequate training for independent living. Thibadeau Tr. 2294:25-2295:12; US Ex. 1115.

827. Similarly, CHDC student TH's transition plan indicates only "communication/language" in the employment section and, in the independent living section, only "food items, self-help skills, recreation/leisure, daily living, and money" are listed. None of these is an appropriate,

measurable transition objective. Thibadeau Tr. 2295:13-2296:8; US Ex. 1116. TH's plan repeats these vague goals from the prior year. Thibadeau Tr. 2296:9-15; US Ex. 1116.

828. CHDC student BM's transition plan contains vague references to "recreation/leisure and adult enrichment," repeated from the prior year, without specifying appropriate measurable goals. Thibadeau Tr. 2296:16-2297:13; US Ex. 1117.

829. Finally, CHDC student DN's IEP transition plan similarly lists only "hand/face washing, pour liquids, matching textures, and money management," none of which satisfy the IDEA's requirement for appropriate, measurable transition goals. These goals also had been continued from multiple prior years. Thibadeau Tr. 2297:14-2298:5; US Ex. 1118.

830. As demonstrated by these inadequate transition goals, CHDC does not administer effective transition plan assessments to develop such goals. CHDC should be engaging the student in discussions and/or assessments to identify his or her interests and strengths, using that as a platform to discuss potential vocational opportunities with the student and his or her family. Instead, CHDC utilizes the reading-free vocational assessment, which involves students pointing to pictures depicting occupations. This assessment is not likely to result in an accurate measurement of students' vocational interests. Thibadeau Tr. 2242:18-2243:16. Even CHDC education staff acknowledge that this assessment is not accurate for all students. Milum Tr. 2135:9-2136:2.

831. When CHDC does solicit input from students regarding their career interests, documented instances show that this input is sometimes ignored. Thibadeau Tr. 2243:17-24, 2354:8-2355:9; US Ex. 2026 at US-CON-E-0031258 and US-CON-E-0031275 (updated IEP transition plans of students TT and CW not reflecting students' stated interests).

832. Further, CHDC makes little attempt to engage outside agencies in planning for students' transition to adult life. Representatives of outside agencies needed for transition do not generally participate in transition planning for CHDC students. Thibadeau Tr. 2181:22-2182:13, 2299:10-24.

833. Without outside agency contact, parents, guardians, and students are not aware of the range of services available in their communities, and service providers do not know about the needs of CHDC students who may need services upon their transition. Thibadeau Tr. 2299:10-19. Lack of outside agency involvement in transition services risks students' ability to access and benefit from services to transition them from secondary education to adult life. This is particularly important for students with needs for comprehensive supports and services. Yet CHDC does not educate parents about the function of outside agencies and the importance of granting permission for outside agency attendance at IEP meetings. Thibadeau Tr. 2299:20-2300:21.

834. ADE also found that CHDC IEP notices to parents do not consistently identify other agency representatives to be invited to participate in IEP meeting transition services discussions. Thibadeau Tr. 2301:10-19. Unless CHDC identifies agency representatives in parental notices, outside agency representatives cannot participate in IEP meetings because the IDEA requires parental consent for their participation. 34 C.F.R. § 300.321(b)(3); Thibadeau Tr. 2300:13-21, 2302:1-2303:1; US Exs. 1104 & 1207.

835. As of ADE's site inspection in January 2010, 28 of 50 students needed appropriate transition services because they were 16 years old or older. Thibadeau Tr. 2293:21; US Ex. 1208.

836. Consistent with Dr. Thibadeau, ADE also found that CHDC students' IEP transition plans did not include appropriate, measurable post-secondary goals based on an age-appropriate transition assessment related to training, education, employment, and, where appropriate, independent living skills, as required by the IDEA. Thibadeau Tr. 2298:19-2299:9, 2302:1-2303:1; Harding Tr. 3002:13-3003:24; US Exs. 1104, 1201 & 1207.

J. CHDC Fails To Educate Students in the Least Restrictive Environment, as Required by the IDEA.

837. Students with disabilities are entitled to be educated in an environment where they have the maximum possible interaction with their non-disabled peers, both in educational and extra-curricular activities. Districts are not authorized to choose a more restrictive placement than that which is appropriate, as the IDEA explicitly requires that "[t]o the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." 20 U.S.C. § 1412(a)(5)(A); *see also* 34 C.F.R. §§ 300.114, 300.117.

838. Contrary to IDEA requirements, CHDC students are not educated in the least restrictive environment, as CHDC is one of the most restrictive environments and no student attends any class or extracurricular activity with his or her non-disabled peers. Thibadeau Tr. 2303:2-2305:10; Milum Tr. 2116:15-2117:3; Smith Tr. 2153:15-17.

839. ADE also found insufficient evidence that CHDC provides students with an equal opportunity for participation in nonacademic and extracurricular activities, including participation with non-disabled students to the maximum extent possible. Thibadeau Tr. 2314:25-2315:11; US Ex. 1201.

840. Defendants' special education consultant, Dr. Bruce Gale, acknowledged that the concept of least restrictive environment has not been fully implemented as to CHDC students. Gale Tr. 5755:20-5756:10. Dr. Gale also admitted that CHDC staff fail to meet their obligation to raise potential alternative placements for students absent a parental request to do so. Gale Tr. 5760:20-5764:3.

841. CHDC students who attended public schools prior to their admission to CHDC used to be able to attend classes and extracurricular activities with their non-disabled peers while in public school. Milum Tr. 2116:4-7; Nye Tr. 5235:23-5240:15; US Exs. 1103-1 through 1103-9.

842. Over the last several years, CHDC has provided less, not more, opportunities for students to participate in mainstreamed activities. CHDC previously provided a few students the opportunity to attend the public schools in Conway under a now-expired agreement with the local school district. Thibadeau Tr. 2314:16-24; Smith Tr. 2153:18-20; Harding Tr. 3026:4-11.

843. Even when CHDC provided *more* options to satisfy its LRE obligations by allowing 3 of the then-36 students at CHDC attended public school activities, ADE nonetheless recommended in 2005 that CHDC provide additional options by actually enrolling students in the local public schools. Harding Tr. 3025:11-3026:3; US Ex. 1186.

844. Instead, CHDC now tries not to admit students who have received educational services with their non-disabled peers because, contrary to IDEA requirements for a full continuum of placement options, public school placement is not made available to CHDC students. *See* 20 U.S.C. § 1412(a)(5); 34 C.F.R. § 300.115.

845. Though CHDC education staff believe the Conway public school system has the responsibility to accept students from CHDC, Milum Tr. 2133:6-9, no CHDC students are allowed to attend any classes with their non-disabled peers. Nye Tr. at 5146:6-5147:9.

846. Some students at CHDC have needs similar to students who attend classes with non-disabled peers in the Conway public school system. Milum Tr. 2115:25-2116:3. Yet these students no longer attend public school, primarily because of reported behavior concerns. Milum Tr. 2116:8-14. Pursuant to their IDEA obligations, special education teachers in public schools commonly address behaviors so students can learn in the classroom. Thibadeau Tr. 2196:11-2197:17, 2200:8-2201:5, 2206:10-24; *see* 20 U.S.C. § 1414(d)(3)(B)(i).

847. Even Defendants' education consultant agrees that once a student's behavioral concerns are addressed, CHDC should be looking for a less restrictive placement for that student. Nye Tr. 5241:14-21.

848. CHDC education staff and individualized education plan teams have expressed concern that CHDC students are not being educated in the least restrictive environment. Thibadeau Tr. 2305:23-2307:14; Milum Tr. 2125:4-9; US Exs. 1191, 1193 & 1196.

849. For example, in at least two special education annual reviews for student LW, CHDC education staff documented their belief that CHDC is not the least restrictive environment for LW. Thibadeau Tr. 2306:4-2307:4; Milum Tr. 2126:3-2128:18; US Exs. 1193 & 1196. LW has not had access to sign language interpretive services at the CHDC school, as CHDC has no sign language interpreters and CHDC education staff are not fluent in sign language. Thibadeau Tr. 2307:15-2308:6; Milum Tr. 2125:10-24; Smith Tr. 2165:9-2166:16; US Ex. 1215. LW would be better served in an educational environment in which he could communicate with his educators and peers. Thibadeau Tr. 2313:19-2314:7. Yet CHDC placed the burden of pursuing a more appropriate placement on LW's parents. Milum Tr. 2148:15-2149:3. Meanwhile, CHDC documented LW's frustration in not being able to communicate via sign language with CHDC staff. Buck Tr. 6528:12-6529:17; Defs. Ex. 483. These problems are not limited to LW. Other

CHDC students have hearing impairments and are therefore similarly deprived of the opportunity to communicate using sign language and to develop sign language skills while at the CHDC school. Milum Tr. 2125:25-2126:2; Smith Tr. 2152:12-14; Buck 6516:9-11.

850. CHDC education staff also documented their belief that the CHDC school is not the least restrictive environment for ZS, as he would likely benefit in a learning environment with students more comparable to his intellectual ability. Thibadeau Tr. 2307:5-14; Milum Tr. 2129:1-3; US Ex. 1191. According to his teacher, ZS is a very attentive student who has mild disabilities, significant academic skills, and enjoys learning, but has not received sufficient special education instructional time for years at CHDC. Milum Tr. 2121:2-2122:3, 2128:21-2131:14; US Exs. 1190 through 1192; *see also* FOF # 27 (ZS's admission to CHDC was supposed to be temporary until waiver services in the community were established for him).

851. Dr. Thibadeau concurs with CHDC education staff's recommendation for a less restrictive educational environment for ZS, as CHDC documentation indicated that ZS's behavior in the classroom had markedly improved and his reading comprehension was only a few years below average. Thibadeau Tr. 2311:15-2312:8; US Exs. 1169, 1190 & 1191.

852. CHDC student records and classroom performance observations indicate that CHDC is not the least restrictive educational environment for additional students. Thibadeau Tr. 2181:14-21, 2305:11-22. For example, Dr. Thibadeau observed CHDC student CA throughout her two weeks on-site, and he interacted well with other individuals and appeared to be capable of following the school routine. With appropriate supports and services, CHDC student CA could be served in a less restrictive environment. Thibadeau Tr. 2309:18-2310:12; US Ex. 1123.

853. CHDC student CL also could be served in a less restrictive environment. CHDC documentation indicates he can read at or above grade level, tell time, complete some addition

problems, and write in print. He is diagnosed with a moderate intellectual disability and autism. Dr. Thibadeau observed CL to be receptive to instruction as well. Thibadeau Tr. 2310:13-2311:2; US Ex. 1147.

854. Similarly, Dr. Thibadeau observed CHDC student JR to be cooperative with instruction, and independently mobile. He is also a good candidate for education in a less restrictive environment. Thibadeau Tr. 2311:3-14; US Ex. 1163.

855. CHDC student TS has intellectual and social functioning levels in the mild to borderline range and had only one behavior report in the month he had been at CHDC. Dr. Thibadeau also observed him interacting appropriately with others, including assisting with lunchtime clean-up. He also could be served in a less restrictive environment. Thibadeau Tr. 2312:9-25; US Ex. 1176.

856. CHDC student SW also has a low frequency of behaviors resulting in behavior reports at CHDC. SW functions intellectually and socially at the moderate level. Dr. Thibadeau observed SW to be capable of appropriately communicating his needs and wants. In sum, SW appeared to be able to benefit from a less restrictive environment. Thibadeau Tr. 2313:1-18; US Ex. 1182.

857. CHDC's efforts to provide community experiences for CHDC students fall far short of the types of regular interactions with non-disabled peers contemplated by the IDEA's least restrictive environment requirement. For example, CHDC responded to ADE's inquiry regarding interactions with non-disabled peers that CHDC students "shop in the community, attend the fair, attend parades, go out to eat, and go to movies." Thibadeau Tr. 2308:7-2309:1; US Ex. 1215. CHDC also attempts to construct community interaction with students by having school bands and choirs perform at CHDC and by having student volunteers occasionally volunteer at CHDC outside of school hours. Thibadeau Tr. 2315:12-2317:21; US Exs. 1226 &

1227. Such sporadic group community outings and occasional on-campus interactions do not enable CHDC students to form social relationships with their non-disabled peers, as would regular attendance in classes and extra-curricular activities – opportunities no CHDC student has. Thibadeau Tr. 2308:7-2309:1, 2317:5-21.

858. Schools are obligated under the IDEA to conduct an independent analysis of whether each student is being educated in the least restrictive environment appropriate to the student's needs. The fact that a parent has not made a request for a more integrated setting does not relieve a school of this obligation. Thibadeau Tr. 2304:4-15.

859. If CHDC were to comply with the IDEA's requirement for local education agency representatives to participate in IEP meetings, CHDC would be better informed about community education options that could enable CHDC students to be served in a less restrictive environment. Thibadeau Tr. 2317:22-2318:12. CHDC's lack of communication and cessation of its relationship with the local school district contribute to the ongoing isolation of students at CHDC in an environment that is highly restrictive. Thibadeau Tr. 2318:13-2319:4.

860. CHDC is a highly restrictive environment in which students' functional skills are not developed, which perpetuates the students' placements in the most restrictive environment on the continuum of special education services. Schools are required to teach students the skills to better prepare them to transition to a less restrictive environment, yet CHDC does not. Thibadeau Tr. 2319:6-25. For example, CHDC students' toileting skills are not developed in CHDC's educational program, Milum Tr. 2142:25-2143:7, and students continue to use Pull-ups or Attends. Thibadeau Tr. 2320:1-13. Similarly, residential staff fail to adequately attend to students' eating plans, providing students with the wrong diets and making no attempts to improve students' eating skills. Thibadeau Tr. 2180:14-2181:1, 2320:14-2321:19.

861. Not only does CHDC's education program fail to address such skills development through students' IEPs, but CHDC's IPPs also fail to encompass all appropriate skill development. For example, CHDC IPPs inappropriately require that students acquire certain skills before learning other unrelated skills, such as teeth brushing before toileting. Thibadeau Tr. 2321:20-2322:17. As another example, CHDC students' schedules include inordinate amounts of time for basic skills development that could be incorporated into daily activity, such as 45 minutes 3 times a week dedicated to hand washing. Thibadeau Tr. 2322:16-2323:3.

K. CHDC Does Not Provide Adequate Teacher Training and Supervision.

862. Education staff must be appropriately and adequately prepared and trained, and those personnel must have the content knowledge and skills to serve children with disabilities. 34 C.F.R. § 300.156(a). To that end, CHDC must take measurable steps to recruit, hire, train, and retain highly qualified personnel to provide special education and related services to children with disabilities. 34 C.F.R. § 300.156(d).

863. CHDC teachers lack adequate training and supervision to appropriately implement students' IEPs. On-site observations revealed that teachers were not able to engage students in learning because they were not familiar with student preferences and interests. Thibadeau. Tr. 2182:14-2183:21.

864. Teachers should be trained to conduct preference assessments and in task analysis, discrete trial instruction, prompting strategies, and planning for maintenance and generalization of skills, yet CHDC teachers do not have this training. Thibadeau Tr. 2193:17-24, 2324:19-2326:12. CHDC teacher Throndia Smith confirms that CHDC does not train its teachers on conducting preference assessments. Smith Tr. 2160:24-2161:5. Rather, as observed by Dr. Thibadeau, CHDC teachers engage in repeated unsuccessful attempts to provide instruction,

without adapting their methods, illustrating how the teachers' lack of training in these areas results in inadequate instruction. Thibadeau Tr. 2325:14-2326:12.

865. CHDC fails to require teachers to receive training in areas relevant to the needs of the students they teach. Smith Tr. 2160:5-7.

866. Defendants' special education consultant, Dr. Gale, agrees that CHDC would benefit from more in-service training in understanding the requirements of the IDEA. Gale Tr. 5723:8-5724:12.

867. The standard in the field of special education requires ongoing teacher supervision by an individual with education and experience in the subjects being taught. None of the four teachers interviewed by Dr. Thibadeau identified a consistent schedule of supervision or support for provision of education services, implementation of behavior support plans, nor communication development. Thibadeau Tr. 2328:7-2329:4, 2329:11-22. Dr. Thibadeau also observed instances of ineffective instruction techniques that could have been corrected with adequate teacher supervision. Thibadeau Tr. 2330:19-2335:4.

868. CHDC supervisory education staff fail to provide substantive oversight or feedback regarding IEP goals or objectives or their implementation. Milum Tr. 2138:25-2139:22.

869. CHDC's special education supervisor is not certified in special education instruction or supervision and therefore has insufficient knowledge of special education requirements. Thibadeau Tr. 2329:5-10. The lead special education teacher called by Defendants to testify has no special education work experience outside of her employment at CHDC. Buck Tr. 6508:8-10.

870. CHDC must adopt effective procedures for acquiring and disseminating to teachers and administrators significant information from educational research, demonstrations, and similar projects, and for adopting, where appropriate, promising educational practices developed through

such projects. 20 U.S.C. § 1232e. ADE found insufficient evidence that CHDC has adopted required promising educational practices for the provision of special education instruction. Thibadeau Tr. 2335:23-2336:12; US Ex. 1104.

871. ADE found that CHDC has no written plan for ongoing staff training or professional development. Thibadeau Tr. 2336:13-20; US Ex. 1198. Without such a plan, CHDC violates the IDEA and its implementing regulations by failing to train teachers to serve students' unique needs and teachers are ill-equipped to teach CHDC students, as CHDC teachers acknowledged in interviews with ADE. Thibadeau Tr. 2336:13-2340:23; US Exs. 1198, 1201 & 1214.

872. Defendants' special education consultant, Derek Nye, testified that it will be time-consuming for CHDC to develop a more systematized form of staff development. Nye Tr. 5167:6-22.

873. CHDC also fails to maintain an education policy manual, Smith Tr. 2152:17-19, and ADE recently directed CHDC to develop one. Milum Tr. 2136:6-12. Although CHDC drafted policies in summer 2010, it has not yet implemented them. Buck Tr. 6520:6-20. Without special education policies, teachers lack direction and oversight.

XV. CONCLUSIONS OF LAW - SPECIAL EDUCATION

A. CHDC's Procedural IDEA Violations Deprive Students of Educational Opportunities.

In *Bd. of Educ. v. Rowley*, 458 U.S. 176 (1982), the Supreme Court established a two-step inquiry for evaluating claims that students have not received a free appropriate public education ("FAPE") under the Education for All Handicapped Children's Act, the predecessor statute to the IDEA. 458 U.S. at 206-07. Under this two-step analysis, a court first evaluates whether a state has complied with statutory procedural requirements. *Id.* at 206. Second, the court determines whether the individualized educational program developed through statutory procedures is

"reasonably calculated to enable the child to receive educational benefits." *Id.* at 206-07. Both requirements must be met. *See id.* As the *Rowley* Court emphasized, "the importance Congress attached to these procedural requirements cannot be gainsaid." *Id.* at 205.

Courts have continued to apply the *Rowley* two-part analysis to post-IDEA cases, looking first to determine whether there were procedural deficiencies before considering whether there are substantive violations. *Lathrop R-II Sch. Dist. v. Gray*, 611 F.3d 419, 424 (8th Cir. 2010); *Yankton Sch. Dist. v. Scramm*, 93 F.3d 1369, 1373 (8th Cir. 1996); *Petersen v. Hastings Pub. Sch.*, 31 F.3d 705, 707 (8th Cir. 1994).

A procedural violation of the IDEA establishes a denial of FAPE if it compromises a student's right to an appropriate education, seriously hampers the parents' opportunity to participate in the IEP process, or causes a deprivation of educational benefits. *Lathrop R-II Sch. Dist.*, 611 F.3d at 424; *Sch. Bd. of Ind. Sch. Dist. No. 11 v. Renollett*, 440 F.3d 1007, 1011 (8th Cir. 2006); *Indep. Sch. Dist. No. 283 v. S.D.*, 88 F.3d 556, 562 (8th Cir. 1996); *Kingsmore v. District of Columbia*, 466 F.3d 118, 119 (D.C. Cir. 2006) (finding a violation of IDEA's procedural requirements "is viable only if those procedural violations affected the student's substantive rights"); *Park v. Anaheim Union High Sch. Dist.*, 464 F.3d 1025, 1031 (9th Cir. 2006) ("relief is appropriate if procedural violations deprive [the student] of an educational opportunity (prejudice) or seriously infringe his parents' opportunity to participate in the formulation of the individualized education plan.").

Routinely failing to offer a full continuum of educational placements, failing to convene IEP teams with all of the IDEA-required members (i.e., the LEA representative and a regular education teacher), failing to develop IEPs that contain appropriate and measurable goals and

objectives, failing to consider IDEA-required factors in developing IEPs, failing to administer statewide and districtwide assessments, and failing to invite a representative from the agency or agencies likely to provide transition services,[8] each constitute a denial of FAPE. Each of these procedural deficiencies deprives CHDC students of the educational benefits to which they are entitled under the IDEA, including opportunities to access public school and other agency resources, to develop skills through measurable IEP goals and objectives, and to benefit from statewide achievement standards.

1. CHDC Does Not Offer Students a Full Continuum of Educational Placements, as Required by the IDEA.

The IDEA requires that each public agency provide students with disabilities, such as those at CHDC, with a full continuum of educational placements, including access to instruction in both special education and regular education classes, as well as access to supplementary services such as resource rooms for augmentation of students' skills in particular subjects.

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[8] Under the IDEA, the term "transition services" means a coordinated set of activities for a child with a disability that--

> (A) is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation;
>
> (B) is based on the individual child's needs, taking into account the child's strengths, preferences, and interests; and
>
> (C) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation.

20 U.S.C. § 1401(a)(34).

20 U.S.C. § 1412(a)(5); 34 C.F.R. § 300.115. "Courts have held that the placement decision must be based on the IEP produced by the IEP team and cannot be made before the IEP is produced." *James D. v. Bd. of Educ.*, 642 F. Supp. 2d 804, 821 (N.D. Ill. 2009) (quoting *Bd. of Educ. of Tp. High Sch. Dist. No. 211 v. Michael R.*, No. 02-6088, 2005 WL 2008919, at *14 (N.D. Ill. Aug. 15, 2005) (citing *Spielberg v. Henrico County Pub. Sch.*, 853 F.2d 256, 258-59 (4th Cir. 1988))). Therefore, a school's "unilateral decision to change a student's placement before the IEP meeting with the student's parents, referred to as 'predetermination,' can constitute a violation of the IDEA." *Id.* Predetermination of a student's educational placement prior to the development of an appropriate IEP at an IEP meeting constitutes a procedural violation of the IDEA resulting in denial of FAPE. *Deal v. Hamilton County. Bd. of Educ.*, 392 F.3d 840, 855-57 (6th Cir. 2004); *Spielberg v. Henrico County. Pub. Sch.*, 853 F.2d 256, 259 (4th Cir. 1988).

The uncontroverted evidence in this case reveals that students entering CHDC have a pre-determined educational placement in an institutional setting, only interacting regularly with peers who have disabilities. There is no opportunity for CHDC students to attend any classes or extra-curricular activities with their non-disabled peers and indeed no plan to facilitate any such activities for any students now that the former agreement between CHDC and the Conway public school district has lapsed. *See* FOF ## 838, 839 & 842. Indeed, as Defendants' special education consultant Derek Nye testified, CHDC's practice is to try not to admit students who have received educational services in a general education curriculum because that educational placement option is not available to CHDC students. *See* FOF # 747. CHDC's special education coordinator, who is not certified in special education, decides without an IEP meeting that the

students to be admitted to CHDC do not need (and will not receive) a full-time education program. *See* FOF # 747.

This unilateral decision to deny CHDC students access to any classes or extra-curricular activities with their non-disabled peers is an unlawful predetermination of CHDC students' educational placements that deprives CHDC students of the full continuum required by the IDEA. Circumventing the IEP team decision through a predetermination is a procedural violation that deprives students of the educational benefits of interaction with their non-disabled peers required by the IDEA's continuum of placements and least restrictive environment provisions. *See* 20 U.S.C. § 1412(a)(5); 34 C.F.R. §§ 300.107 & 300.115.

2. CHDC Fails To Satisfy the IDEA's Requirement That an LEA Representative and a Regular Education Teacher Attend IEP Meetings for CHDC Students.

The IDEA prescribes the required members of the team who must meet to evaluate special education needs for students with disabilities (the "IEP team"). Specifically, 20 U.S.C. § 1414(d)(1)(B) provides:

> The term "individualized education program team" or "IEP Team" means a group of individuals composed of --
>
> (i) the parents of a child with a disability;
>
> (ii) *not less than one regular education teacher of such child* (if the child is, or may be, participating in the regular education environment);[9]

[9] Regular education teachers play a critical role in developing an IEP:

> Very often, regular education teachers play a central role in the education of children with disabilities (H. Rep. No. 105-95, p. 103 (1997); S. Rep. No. 105-17, p. 23 (1997)) and have important expertise regarding the general curriculum and the general education environment. Further, with the emphasis on involvement and progress in the general curriculum added by the IDEA Amendments of 1997, regular education teachers have an increasingly critical role (together with special

> (iii) not less than one special education teacher, or where appropriate, at least one special education provider of such child;
>
> (iv) *a representative of the local educational agency* who-
>
> > (I) is qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities;
> >
> > (II) is knowledgeable about the general curriculum; and
> >
> > (III) is knowledgeable about the availability of resources of the local educational agency;
>
> (v) an individual who can interpret the instructional implications of evaluation results, who may be a member of the team described in clauses (ii) through (vi);
>
> (vi) at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; and
>
> (vii) whenever appropriate, the child with a disability.

20 U.S.C. § 1414(d)(1)(B) (emphasis added);[10] *see also* 34 C.F.R. §§ 300.321(a)(2), 300.324(a)(3), 300.324(b)(3).

The IDEA provides a limited exception under which certain required team members may be exempt from meeting participation – but *only if* the student's parents and the local educational agency consent in writing, *and* the missing team member submits, in writing to the parent and the IEP Team, input into the development of the IEP prior to the meeting. 20 U.S.C. § 1414(d)(1)(C).

> education and related services personnel) in implementing the program of FAPE for most children with disabilities, as described in their IEPs.

M.L. v. Fed. Way Sch. Dist., 394 F.3d 634, 643 (9th Cir. 2005) (citing 34 C.F.R. § 300, App. A).

[10] The IDEA also provides that "[t]he regular education teacher of the child, as a member of the IEP Team, shall, consistent with [§ 1414(d)(1)(C)], participate in the review and revision of the IEP of the child." 20 U.S.C. § 1414(d)(4)(B).

The requirement for a regular education teacher to participate in students' IEP meetings is mandatory if the student is *or may be* participating in the regular educational environment. *See* 34 C.F.R. §§ 300.321(a)(2), 300.324(a)(3), 300.324(b)(3); *see also M.L.*, 394 F.3d at 643-44 (noting that the "plain meaning" of this provision of the IDEA "compels the conclusion that the requirement that [at] least one regular education teacher be included on an IEP team, if the student may be participating in a regular classroom, is mandatory – not discretionary").

Similarly, each IEP team meeting *must* include a local education agency representative ("LEA representative") who is "qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities, is knowledgeable about the general curriculum, and is knowledgeable about the availability of resources of the local educational agency." 20 U.S.C. § 1414(d)(1)(B)(iv). This requirement also is mandatory, not discretionary. *See id.*

IEP teams for CHDC students routinely do not include an LEA representative. *See* FOF ## 736-737, 739-740. This deficiency causes harm to CHDC students because there is no IEP team participant that can fulfill the LEA representative's role of facilitating CHDC student access to the general education curriculum and the resources of the local educational agency. *See* 20 U.S.C. § 1414(d)(1)(B)(iv). As a result, there is no meaningful discussion of less restrictive alternatives for the student available in the public schools.

Nor do IEP teams for CHDC students routinely include a regular education teacher. *See* FOF ## 736, 738 & 740. Defendants have contended that regular education teachers are not included because no CHDC student attends class with his or her non-disabled peers and it is therefore not "likely" that the student would attend general education classes. This is contrary to

the statutory language requiring regular education teacher participation if a student "may be" participating in the regular education environment. *See* 20 U.S.C. § 1414(d)(1)(B). This is also contrary to documented evidence that CHDC is not the least restrictive environment for all students, and that some should be participating to some extent in the regular education environment. *See* FOF ## 839-857. The State cannot provide CHDC students with opportunities to attend class or extra-curricular activities with their non-disabled peers, *see* 34 C.F.R. §§ 300.107, 300.115, if regular education teachers and an LEA representative do not routinely participate in CHDC student IEP meetings. *See* 20 U.S.C. § 1414(d)(1)(B).

3. CHDC IEPs Do Not Comply with the IDEA's Requirement for Appropriate, Measurable Goals and Objectives.

The IDEA requires that each student's IEP contain "a statement of measurable annual goals, including academic and functional goals." 20 U.S.C. § 1414(d)(1)(A)(i)(II); *see also* 34 C.F.R. § 300.320(a)(2). This requirement is important because IEPs must address all areas affecting students' ability to learn, including both academic and functional deficits, and must specify how goals will be measured, so that it is clear whether educational interventions are working for the student. IEPs must also contain appropriate, measurable transition goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills and the transition services needed to reach these goals. 34 C.F.R. § 300.320(b).

Most courts have addressed claims regarding an alleged lack of measurable goals as a procedural violation. *See James D.*, 642 F. Supp. 2d at 817 n.9 (citing *Edwin K. v. Jackson*, No. 01-7115, 2002 WL 1433722, at *13 (N.D. Ill. July 02, 2002); *Stanley C. v. M.S.D. of Sw. Allen County. Sch.*, 628 F. Supp. 2d 902, 961-62 (N.D. Ind. 2008); *Virginia S. v. Dep't of Educ.*, No.

06-128, 2007 WL 80814, at *7 (D. Haw. Jan. 8, 2007); *Leticia H. v. Ysleta Indep. Sch. Dist.*, 502 F. Supp. 2d 512, 518 (W.D. Tex. 2006); *D.B. v. Ocean Twp. Bd. of Educ.*, 985 F. Supp. 457, 536 (D.N.J. 1997); *M.C. v. Rye Neck Union Free Sch. Dist.*, No. 06-3898, 2008 WL 4449338, at *11 (S.D.N.Y. Sept. 29, 2008); *Adam J. ex rel. Robert J. v. Keller Indep. Sch. Dist.*, 328 F.3d 804, 811 (5th Cir. 2003)); *but see Caitlin W. v. Rose Tree Media Sch. Dist.*, No. 03-6051, 2009 WL 1383304, at *6 (E.D. Pa. May 15, 2009) (analyzing alleged deficiencies in IEPs, including alleged lack of measurable goals, under the *Rowley* substantive analysis); *Kevin T. v. Elmhurst Cmty. Sch. Dist. No. 205*, No. 01-005, 2002 WL 433061, at *5 (N.D. Ill. Mar. 20, 2002) (same).

The testimony of the United States' special education expert, the ADE Special Education Director, and Defendants' special education consultants demonstrates that CHDC's IEPs do not contain appropriate, measurable goals and objectives. *See* FOF ## 764-773. Dr. Thibadeau's testimony illustrates and provides examples of how CHDC's limited IEP goals and objectives are not sufficient in number or quality and are not measurable, depriving students of educational benefits. *See* FOF ## 765, 767-769. Although each IEP must include goals "designed to (aa) meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum; and (bb) meet each of the child's other educational needs that result from the child's disability," 20 U.S.C. § 1414(d)(1)(A)(i)(II), some IEPs only include two objectives for an entire year. *See* FOF # 767. Other IEPs include only four objectives, two of which begin only after the other two are completed. *See* FOF # 767.

ADE also criticized CHDC for limiting its IEP development to academic goals. *See* FOF # 766. Consistent with Dr. Thibadeau's opinion, ADE also found that in many cases, CHDC IEP goals and objectives are poorly written, the objectives often do not relate to the goals, and the objectives do not address the specific needs of the student. For example, ADE found that student

BM's IEP contained the same objectives two years in a row, and those objectives only addressed the use of a wheelchair. *See* FOF # 771. ADE also found that student CA's IEP goals and objectives had little connection to each other and to CA's needs, as the student had a two-year-old functional speech level and could only say a few words but was supposed to be "learning the language of algebra." *See* FOF # 771.

Defendants' special education consultant, Derek Nye, concurs with Dr. Thibadeau that at least some CHDC IEP objectives are not clear, particularly with regard to the conditions under which tasks were to be performed. Mr. Nye acknowledges that CHDC education staff would benefit from training regarding the writing of IEP goals and objectives. *See* FOF # 772. Defendants' second special education consultant, Dr. Bruce Gale, testified that goal writing appears to be the biggest problem with CHDC IEPs. *See* FOF # 773.

CHDC IEP transition goals also violate IDEA requirements because they are neither appropriate nor measurable. CHDC students' transition plans do not clearly specify what skills the student is learning or how student performance will be measured. *See* FOF ## 824-829. Even Defendants' special education consultant, Derek Nye, found that CHDC transition plans lack clarity and fail to contain measurable goals, as required by the IDEA. *See* FOF # 825. Consistent with Dr. Thibadeau, ADE also found that CHDC students' IEP transition plans did not include appropriate, measurable post-secondary goals based on an age-appropriate transition assessment related to training, education, employment, and, where appropriate, independent living skills, as required by the IDEA. *See* FOF # 836.

All of these deficiencies in IEP goals and objectives violate the IDEA's procedural requirements and deprive CHDC students of educational benefits because students cannot

receive comprehensive services if their IEPs do not map out the required level of services to meet their academic, functional, and transition needs and provide the required mechanism for measuring progress.

4. CHDC IEP Teams Fail To Consider IDEA-Required Factors in Developing Students' IEPs.

The IDEA prescribes certain required factors that IEP teams must consider in developing students' IEPs, including students' academic, developmental, functional, and communication needs. 34 C.F.R. § 300.324(a). The evidence demonstrates that CHDC IEP teams do not consider all of the IDEA-required factors, resulting in IEPs that do not provide comprehensive services to students. CHDC assessment tools do not address all necessary areas of development to enable accurate assessment of present levels of performance and appropriate development of goals and objectives because these assessment tools fail to assess functional skill development in areas such as communication, self-help, domestic, leisure, and vocational skills; skill development in these areas is particularly important for older students. 34 C.F.R. § 300.324(a)(1)(iv); *see* FOF ## 782-783.

The IDEA also requires that assessments be administered in a manner that meets the communication style of the individual who is being assessed. 34 C.F.R. § 300.304(c)(1)(ii). CHDC has not met this obligation because it has not offered these assessment accommodations to all students with disabilities. For example, a CHDC student with a visual impairment did not receive an assessment because it was typically offered in pictoral form, and a CHDC student with a hearing impairment did not receive a different assessment because a sign language interpreter was not available. *See* FOF # 787.

5. CHDC Fails To Ensure That CHDC Students Receive Regular or Alternate Statewide or Districtwide Assessments, as Required by the IDEA.

The IDEA, in addition to the No Child Left Behind Act, requires that students with disabilities participate in statewide assessments to the same extent as their non-disabled peers – by participating in: (1) general statewide assessments without accommodations; (2) general statewide assessments with accommodations; or (3) alternate assessments. *See* 20 U.S.C. § 1412(a)(16) (requiring that "[a]ll children with disabilities are included in all general State and districtwide assessment programs, including assessments described under [20 U.S.C. § 6311], with appropriate accommodations and alternate assessments where necessary and as indicated in their respective individualized education programs"). To the extent that schools deem alternate assessments more appropriate for students with disabilities than general assessments, alternate assessments must be "aligned with the State's challenging academic content standards and challenging student academic achievement standards" and "measure the achievement of children with disabilities against those standards." 20 U.S.C. § 1412(a)(16).

CHDC students do not receive: (1) general statewide assessments without accommodations; (2) general statewide assessments with accommodations; or (3) alternate assessments. *See* FOF # 780. The State's failure to ensure that each CHDC student participates in statewide and districtwide assessment programs violates the IDEA and deprives CHDC students of the opportunity to access and benefit from the State's challenging academic content standards and student academic achievement standards. *See* 20 U.S.C. § 1412(a)(16); *see also Leighty v. Laurel Sch. Dist.*, 457 F. Supp. 2d 546, 561 (W.D. Pa. 2006) (citing 20 U.S.C. § 1412(a)(16) and noting that "Congress has made it clear that, to the extent possible, disabled children are to be educated and assessed in the same manner as their nondisabled peers"). Without these required statewide and districtwide assessments, there is no indication of whether

CHDC students are accessing and benefitting from the State's academic standards, and students' educational opportunities suffer.

6. CHDC Routinely Fails To Invite a Representative of the Agency or Agencies Likely To Provide Transition Services To Assist CHDC Youth in Transitioning to Postsecondary Educational Services or to a Less Restrictive Environment.

The IDEA requires that, to the extent appropriate, schools invite a representative of any public agency that is likely to provide transition services to a student's IEP meeting if transition services are to be discussed, with the student or parent's consent (when the student has not reached the age of majority). 34 C.F.R. § 300.321(b). Absent outside agency representation, there is no individual at the IEP meetings with the knowledge of and ability to facilitate students' transition from secondary school to post-secondary adult life, which is particularly harmful for students such as those at CHDC, who have ongoing needs for comprehensive services and supports.

Both the United States' special education expert and Defendants' special education consultant Bruce Gale found that outside agency representatives do not participate in IEP meetings for CHDC students, as required by the IDEA. *See* FOF ## 831-832. This deficiency deprives CHDC students of important opportunities to access services that may be provided by outside agencies to facilitate postsecondary education or education in a less restrictive environment.

ADE also cited CHDC for non-compliance with due process standards because, pursuant to ADE's evaluation, "[t]here was insufficient evidence" that notices to parents identify any other agency or agencies that will be invited to send a representative to CHDC student IEP meetings to discuss transition services. *See* FOF # 834. Without notifying parents of the outside

agency or agencies who may be invited to send a representative to participate in IEP meeting discussions regarding transition services, CHDC cannot obtain the required parental consent for the agency representative's participation. As a result, CHDC students are deprived of a key voice in the conversation identifying appropriate transition services.

B. CHDC Students' IEPs and Services Provided Therein Are Not Reasonably Calculated To Enable CHDC Students To Receive Educational Benefits.

Under *Rowley*, even if the State has complied with the procedural requirements of the IDEA, FAPE is not met unless "the individualized educational program developed through the Act's procedures [is] reasonably calculated to enable the child to receive educational benefits." 458 U.S. at 206-07; *see also Lathrop R-II Sch. Dist.*, 611 F.3d at 424 (applying two-step *Rowley* analysis to IDEA case); *Gill v. Columbia 93 Sch. Dist.*, 217 F.3d 1027, 1035 (8th Cir. 2000) ("The standard to judge whether an IEP is appropriate under IDEA is whether it offers instruction and supportive services reasonably calculated to provide some educational benefit to the student for whom it is designed.").

The education offered to CHDC students is not reasonably calculated to provide education benefit in that: (1) students are not all in the least restrictive environment, *see* FOF ## 837-859, and CHDC services do not target skill development to allow progress toward more integrated settings, *see* FOF # 860-861; (2) related services necessary to allow students to benefit from instruction are not offered to all students, *see* FOF ## 788-822; (3) assistive technology necessary for students to benefit from instruction is not always functional, *see* FOF ## 806-810; (4) students are not receiving adequate hours of instruction, *see* FOF ## 741-763; (5) transition planning does not address student needs and lacks outside agency participation, *see* FOF ## 823-836; and (6) teachers lack adequate training and supervision to appropriately implement

students' IEPs and collect reliable data regarding students' skill acquisition and behavior reduction. *See* FOF ## 862-873.

1. CHDC Students Are Not All Receiving Education and Extra-Curricular Activities in the Least Restrictive Environments Appropriate to Their Needs.

Educating children in the least restrictive environment in which they can receive an appropriate education is one of the IDEA's most important substantive requirements, "reflecting [the IDEA's] 'strong preference' that disabled children attend regular classes with non-disabled children and a presumption in favor of placement in the public schools." *T.F. v. Special Sch. Dist. of St. Louis County*, 449 F.3d 816, 820 (8th Cir. 2006) (quoting *S.D.*, 88 F.3d at 561). The IDEA explicitly requires that, "[t]o the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." 20 U.S.C. § 1412(a)(5)(A); *see also* 34 C.F.R. §§ 300.114 & 300.117.

In interpreting this statutory requirement, the Eighth Circuit has stated: "Children who can be mainstreamed should be mainstreamed, if not for the entire day, then for part of the day; similarly, children should be provided with an education close to their home, and residential placements should be resorted to only if these attempts fail or are plainly untenable." *T.F.*, 449 F.3d at 820 (internal quotation marks omitted). Because "the IDEA creates a preference for mainstream education," placement in a segregated setting is appropriate "only if the services that

make segregated placement superior cannot be feasibly provided in a non-segregated setting." *Pachl v. Seagren*, 453 F.3d 1064, 1067 (8th Cir. 2006) (internal quotations omitted).[11]

The IDEA requires that states educate students with disabilities alongside students who do not have disabilities whenever possible. *Rowley*, 458 U.S. at 202. As the *Rowley* Court noted, "[w]hen that 'mainstreaming' preference of the Act has been met and a child is being educated in the regular classrooms of a public school system, the system itself monitors the educational progress of the child." *Id.* at 202-03. This is because "[r]egular examinations are administered, grades are awarded, and yearly advancement to higher grade levels is permitted for those children who attain an adequate knowledge of the course material." *Id.* at 203. Accordingly, "[t]he grading and advancement system thus constitutes an important factor in determining educational benefit." *Id.* Similarly, the IDEA articulates the purpose of integration by explaining that the best outcomes for children with disabilities result from "having high expectations for such children and ensuring their access to the general education curriculum in the regular classroom, to the maximum extent possible." 20 U.S.C. § 1400(c)(5)(A).

[11] *Pachl* notes that removing a child from the mainstream setting is permissible when "the handicapped child would not benefit from mainstreaming, when any marginal benefits received from mainstreaming are far outweighed by the benefits gained from services which could not feasibly be provided in the non-segregated setting, and when the handicapped child is a disruptive force in the non-segregated setting." 453 F.3d at 1068 (internal quotation marks omitted). To the extent Defendants claim that students are at CHDC for behavioral reasons, the Eighth Circuit has held that removal of a dangerous child with a disability from her current educational placement due to behavioral issues must be supported by evidence "(1) that maintaining the child in that placement is substantially likely to result in injury either to himself or herself, or to others, and (2) that the school district has done all that it reasonably can to reduce the risk that the child will cause injury." *Light v. Parkway C-2 Sch. Dist.*, 41 F.3d 1223, 1228 (8th Cir. 1994). The records produced by Defendants do not include evidence supporting these exceptions, particularly considering that CHDC students are not mainstreamed to *any* extent, unlike in *Pachl*, which involved a dispute between 70% and 100% mainstreaming. *See Pachl*, 453 F.3d at 1068-69.

At CHDC, however, students are not benefitting from instruction alongside non-disabled peers. CHDC IEPs do not indicate a grade level, and students do not receive grades as they do in public schools. *See* FOF # 777. Students also no longer have the opportunity to participate in statewide and districtwide assessments, *see* FOF # 780; 20 U.S.C. § 1412(a)(16), and IEPs are not appropriately modified when students exhibit lack of progress. *See* FOF ## 774-775; *M.M. v. Special Sch. Dist. No. 1*, 512 F.3d 455, 461 (8th Cir. 2008) ("The IDEA required the District to revise [the student's] IEP as appropriate to address any lack of expected progress toward the annual goals and in the general education curriculum.") (internal quotation marks omitted). The undisputed fact that no CHDC student attends a single class or extracurricular activity with his or her non-disabled peers establishes that CHDC students are not educated in the least restrictive environment, in violation of the IDEA. *See* FOF # 838. Nor is there any indication from any of CHDC students' IEPs that IEP teams conducted the required analysis of whether "the services that make segregated placement superior cannot be feasibly provided in a non-segregated setting." *Pachl*, 453 F.3d at 1067-68.

Instead, CHDC teachers have noted that CHDC is not the least restrictive environment for educating all CHDC students, *see* FOF ## 848-850, and IEP teams routinely and unlawfully "check the boxes" justifying the most restrictive placement possible for CHDC students, without any explanation of how the Eighth Circuit's required showing is met. *See Indep. Sch. Dist. No. 284 v. A.C.*, 258 F.3d 769, 774 (8th Cir. 2001) ("We have reversed a state decision concerning an IEP where no *educational* reasons were given for placing a disabled child in a separate learning environment.") (emphasis added).[12] This requirement cannot be overridden for the convenience

[12] Notably, the missing reason must be "educational," not behavioral, as any purported reason for educating CHDC students solely at CHDC appears to be. *See A.C.*, 258 F.3d at 774.

of administrators. *See Pachl*, 453 F.3d at 1070 ("As the Pachls note, under the IDEA, state educational agencies such as the Department have affirmative responsibilities to ensure that the provisions of the IDEA requiring placement in the least restrictive environment are implemented."); *T.F.*, 449 F.3d at 821 ("[T]he school district should have had the opportunity, *and to an extent had the duty*, to try these less restrictive alternatives before recommending a residential placement.") (emphasis added).

Students' emotional or behavioral issues, or an apparent lack of community mental health services, cannot be an excuse to institutionalize youth and educate those same youth in the most restrictive environment; rather, students must be provided with appropriate supports and services in order to benefit from educational services in the least restrictive educational environment. *See* 20 U.S.C. § 1414(d)(3)(B)(i) (requiring an IEP team to, "in the case of a child whose behavior impedes the child's learning and that of others, consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior"). In addition to the IDEA's requirement for provision of appropriate behavioral supports and services, the IDEA specifically requires that education be provided in the least restrictive environment. *Pachl*, 453 F.3d at 1067 (noting IDEA incorporates a clear "preference for mainstream education").

CHDC students also do not participate in extracurricular activities with their non-disabled peers on a regular basis. *See* FOF # 838. Federal law requires that, "[i]n providing or arranging for the provision of nonacademic and extracurricular services and activities, including meals, recess periods, and the services and activities set forth in [34 C.F.R.] § 300.107, each public agency must ensure that each child with a disability participates with nondisabled children in the extracurricular services and activities to the maximum extent appropriate to the needs of that child." 34 C.F.R. § 300.117. Such nonacademic and extracurricular services and activities

include "counseling services, athletics, transportation, health services, recreational activities, special interest groups or clubs sponsored by the public agency, referrals to agencies that provide assistance to individuals with disabilities, and employment of students, including both employment by the public agency and assistance in making outside employment available." 34 C.F.R. § 300.107(b). CHDC's predetermined placement of all students at the CHDC school, with only sporadic interaction with their non-disabled peers, falls woefully short of satisfying the requirements of federal law, and CHDC students continue to not receive the IDEA-mandated educational benefit of interaction with their non-disabled peers.

2. CHDC Does Not Provide Related Services, Including Communication/Audiology and Behavioral/Psychology Services, to All Students Who Require Such Services.

The IDEA requires that students receive any related services that are necessary for them to access and benefit from education. 20 U.S.C. §§ 1400(d)(1)(A), 1401(9), 1401(26)(a). Related services include "transportation, and such developmental, corrective, and other supportive services [such as] speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, school nurse services . . ., counseling services, including rehabilitation counseling, orientation and mobility services, and medical services." 20 U.S.C. § 1401(26)(a). Provision of all appropriate related services is a requirement under the IDEA for which denial can result in the failure to provide FAPE. *Neosho R-V Sch. Dist. v. Clark*, 315 F.3d 1022, 1026-30 (8th Cir. 2003).

CHDC does not provide related services to all students who require them, including speech services, communication device implementation, psychological/behavioral services, and sign language interpretative services. *See* FOF ## 789-794, 802-806, 811-820. Related services

also are not integrated with other CHDC services, resulting in additional gaps in services to CHDC students and in insufficient information shared among educational staff regarding the efficacy of services that are in place. *See* FOF ## 795-801. ADE itself found numerous examples of CHDC students whose education files indicated that they were not receiving all required related services, such as communication and behavioral/mental health services, including students BR, BB, KF, CW, and MB. *See* FOF ## 790-791, 814.

The IDEA requires that, if a student's behavior or other special factor impacts his or her learning, the student's IEP must address that need. 20 U.S.C. § 1414(d)(3)(B)(i) (The IDEA requires an IEP team to, "in the case of a child whose behavior impedes the child's learning and that of others, consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior."). Schools deprive students of educational benefits, and violate the IDEA, when they fail to develop and implement behavior management plans as appropriate. *See, e.g.*, *Neosho R-V Sch. Dist.*, 315 F.3d at 1029-30.

According to CHDC IEPs, many CHDC students were placed at CHDC because of their behaviors. *See* FOF # 812. CHDC IEPs also indicate that students have behavioral problems calling for behavioral services, yet these IEPs do not list any such services being considered or provided. *See* FOF # 792. Nor does CHDC use functional behavior assessments with all CHDC students and, to the extent CHDC uses functional behavioral assessments, they are not comprehensive in scope. *See* FOF # 812. In addition, despite the fact that a significant percentage of youth admitted to CHDC were admitted in part because of behavioral problems, CHDC does not even offer any counseling or psychotherapy services. *See* FOF # 794.

Consistent with Dr. Thibadeau's observations, ADE also noted that in most cases, students' education files do not include behavior plans or goals and objectives to address behavior in the education setting. *See* FOF # 813. ADE also found that CHDC did not necessarily address problem behaviors in the classroom for students who were on shortened school days reportedly for behavior issues. *See* FOF # 813.

All students who require communication skills development are entitled to and should be receiving such related services; otherwise, these students are not receiving FAPE. 20 U.S.C. §§ 1414(d)(3)(B)(iv), 1401(2), 1401(26)(a). Both Dr. Thibadeau and ADE found a number of CHDC students who should be receiving communication services but are not. *See* FOF ## 802-810. Only 7 of the 21 non-verbal school-aged children at CHDC have augmentative communication devices. *See* FOF # 807. For the small number of CHDC students provided assistive technology, CHDC staff does not encourage the use of these devices and, consequently, students do not consistently use them. *See* FOF # 807. ADE also found instances of CHDC students not having access in the classroom to their alternative or augmentative communication devices, such as communication books or other communication devices. *See* FOF # 808.

3. CHDC Fails To Ensure That Hearing Aids Worn by Students with Hearing Impairments Are Functioning Properly, as Required by the IDEA.

The IDEA and its implementing regulations require that each public agency ensure that hearing aids worn in school by children with hearing impairments are functioning properly. 34 C.F.R. § 300.113(a); *J.W. v. Fresno Unified Sch. Dist.*, 626 F.3d 431, 433 (9th Cir. 2010). Students with hearing impairments need consistent access to properly functioning assistive technology to access and benefit from educational services. Clearly, if a student cannot hear the educational instruction being presented, he or she cannot benefit from it.

As demonstrated by ADE's findings and related testimony, CHDC fails to ensure that hearing aids worn by students with hearing impairments are functioning properly. *See* FOF # 809-810. This violation has deprived CHDC students with hearing impairments of educational benefits, including students LW, JB, and BB. *See* FOF # 809. ADE also found no evidence at CHDC of follow-up regarding poor vision and hearing and no evidence of formal augmentative alternative communication assessments in CHDC education files. *See* FOF # 810.

4. CHDC's Provision of a Shortened School Day for All Students Violates the IDEA.

CHDC's decision to provide a shortened school day to all students, regardless of their individual needs, violates the IDEA. CHDC students are entitled to a school day that is just as substantial as their non-disabled peers. Ark. Admin. Code § 005.18.2-2.15.3. Accordingly, CHDC students are entitled to a six-hour instructional day. Ark. Admin. Code § 005.15.14-3. An instructional day means the amount of time spent engaged in instructional activities and excludes lunch, recess and nonacademic or extracurricular activity periods, unless such activities are considered as special education instruction on the individual student's IEP. Ark. Admin. Code § 005.18.2-2.43. If CHDC students receive special education and related services that fail to meet the "standards of the State educational agency," they are not receiving a FAPE. 20 U.S.C. § 1401(9)(B). The undisputed evidence shows that no CHDC student receives six hours of planned instruction, as defined by Arkansas law. Rather, CHDC's planned instructional time of 1.5 to 2.5 hours per day falls woefully short of the required 6-hour school day for students with and without disabilities. *See* FOF ## 741-763. Defendants' failure to provide all CHDC students with an instructional day that complies with Arkansas state law violates the IDEA.

CHDC has determined that no student will receive a full day of educational instruction and has instead assigned all students to shortened school days of between 1.5 and 2.5 hours. *See* FOF ## 744-745. CHDC's uncertified special education coordinator separately admitted to Defendants' special education consultant that she pre-determines that new school-aged admissions to CHDC do not need (and will not receive) a full-time education program. *See* FOF # 747. This blanket policy violates students' IDEA rights to an education that meets the State Education Agency's standards. As ADE found, CHDC fails to make individualized determinations of the appropriate length of an instructional day for any of its students, all of whom are placed on shortened school days in violation of the IDEA. *See* FOF ## 750-752.

5. CHDC's Transition Planning and Transition Services Do Not Satisfy IDEA Requirements.

The IDEA requires that, once a student with disabilities turns 16 years old, schools provide a coordinated set of services to support the student as he or she moves from secondary education to post-secondary life, including vocational training, independent living skills, and supported employment. 34 C.F.R. § 300.320(b). Transition services for CHDC students do not address the needs of students who are 16 years or older because CHDC students' IEPs do not contain appropriate, measurable goals for transition services by failing to clearly specify what skills the student is learning or how student performance will be measured. *See* FOF ## 824-829. Even Defendants' special education consultant, Derek Nye, found that CHDC transition plans lack clarity and fail to contain measurable goals, as required by the IDEA. *See* FOF # 825.

Further, CHDC makes little attempt to engage outside agencies in planning for students' transition to adult life, often failing to request parental permission and always failing to advise parents of the importance of granting permission for outside agency attendance at IEP meetings.

See 34 C.F.R. § 300.321(b); FOF # 832. As a result, representatives of outside agencies needed for transition do not generally participate in transition planning for CHDC students. *See* FOF ## 832-836. Without outside agency contact, parents, guardians, and students are not aware of the range of services available in their communities, and service providers do not know about the needs of CHDC students who may need services upon their transition. *See* FOF # 833. Lack of outside agency involvement in transition services risks students' ability to access and benefit from services to transition them from secondary education to adult life, which is particularly important for students who need comprehensive supports and services. *See* FOF # 833.

6. Education Staff Lack Adequate Training and Supervision To Appropriately Implement Students' IEPs.

Education staff must be appropriately and adequately prepared and trained, and those personnel must have the content knowledge and skills to serve children with disabilities. 34 C.F.R. § 300.156(a). To that end, CHDC must take measurable steps to recruit, hire, train, and retain "highly qualified" personnel to provide special education and related services to children with disabilities. 34 C.F.R. § 300.156(d). CHDC teachers lack adequate training and supervision to appropriately implement students' IEPs and collect reliable data regarding students' skill acquisition and behavior reduction. On-site observations revealed that teachers were not able to engage students in learning because they were not familiar with student preferences and interests. *See* FOF # 863. CHDC teacher Throndia Smith confirms that CHDC does not require teachers to receive training in areas relevant to the needs of the students they teach or train teachers on conducting preference assessments. *See* FOF ## 864-865.

CHDC related services staff lack training in special education, and education staff lack training in related services. *See* FOF # 801. When ADE provided training to CHDC psychology

staff regarding their IDEA obligations in July 2010, staff indicated a lack of understanding regarding their responsibilities and appeared to be under the mistaken impression that they were only charged with meeting ICF/MR CMS funding standards. *See* FOF # 801. Defendants' special education consultant, Dr. Gale, agrees that CHDC would benefit from more in-service training in understanding the requirements of the IDEA. *See* FOF # 866.

CHDC must adopt effective procedures for acquiring and disseminating to teachers and administrators significant information from educational research, demonstrations, and similar projects, and for adopting, where appropriate, promising educational practices developed through such projects. 20 U.S.C. § 1232e. ADE found insufficient evidence that CHDC has adopted the required promising educational practices for the provision of special education instruction. *See* FOF # 870. In sum, CHDC education staff are not appropriately and adequately prepared and trained, with the content knowledge and skills to serve children with disabilities, as required by the IDEA. *See* FOF ## 862-873.

C. CHDC's Failure To Meet the Standards of the State Educational Agency Establishes an Independent Basis for Findings of IDEA Violations.

Under the IDEA, in order to provide FAPE, a disabled student's IEP must "meet the standards of the State educational agency." 20 U.S.C. § 1401(9)(B). ADE recently cited CHDC for failing to make FAPE available to all students with identified disabilities, as required by federal and state law. *See* FOF ## 727-728. ADE found many of the same IDEA deficiencies as the United States' special education expert.

ADE based its determination that CHDC fails to provide FAPE on 15 areas of non-compliance with federal and state special education requirements, including four findings of non-compliance regarding IEP requirements. Regarding IEPs, ADE found that: (1) CHDC fails to

consider special factors that impede a student's learning or that of others when developing the student's IEP; (2) IEP components do not address the unique needs of individual students; (3) CHDC transition plans are neither based on age appropriate transition assessments nor describe appropriate measurable post-secondary goals; and (4) parents are not informed of CHDC student progress toward meeting annual goals and short term objectives on a quarterly basis. See FOF # 730. CHDC's failure to meet the standards of the State educational agency independently establishes IDEA violations pursuant to 20 U.S.C. § 1401(9)(B).

In sum, Defendants unlawfully deprive CHDC students of educational benefits because: (1) CHDC does not offer students a full continuum of educational placements; (2) neither an LEA representative nor a regular education teacher routinely attends CHDC IEP meetings; (3) CHDC IEPs do not contain appropriate, measurable goals and objectives; (4) CHDC IEP teams fail to consider IDEA-required factors in developing students' IEPs; (5) CHDC students do not receive regular or alternate statewide or districtwide assessments; and (6) CHDC routinely fails to invite agency representatives to assist CHDC youth in transitioning to postsecondary services.

The evidence also proves that CHDC student IEPs and the services provided therein are not reasonably calculated to enable CHDC students to receive educational benefits because: (1) students do not spend adequate time in special education classes; (2) related services are not provided to all students who require them; (3) transition planning does not address student needs and lacks outside agency participation; (4) students are not being educated in the least restrictive environment; (5) CHDC services do not target skill development to allow progress toward more integrated settings; and (6) education staff lack adequate training and supervision to appropriately implement students' IEPs.

Finally, Defendants violate the IDEA because CHDC's educational services do not meet the standards of the state educational agency - ADE.

XVI. CONCLUSION

Defendants' system for delivering care and services to CHDC residents illegally condemns individuals at CHDC to lifelong institutionalization. The vast majority of people currently living at CHDC were first admitted as children, many of them not even ten years old. Once admitted, most CHDC residents spend the rest of their lives within the confines of the institution, never re-joining the communities and families from which they came, nor given a meaningful opportunity to maximize their capacity for independent, self-directed living. CHDC currently admits more children than adults, discharges just a handful of people to more integrated settings each year, and plans for the long-term stay of virtually all of its other residents, even the youngest.

Defendants promote this lifelong institutionalization by depriving residents and their guardians of information that is critical to their ability to make informed decisions about whether CHDC is the most integrated setting appropriate to residents' needs. An objective, reasonable assessment – one that is based solely on a resident's specific needs and capabilities and identifies the particular services necessary to meet those needs and maximize those capabilities – is essential for families making important, often difficult, placement decisions. Without independent, reasonable assessments, guardians naturally are inclined to maintain the *status quo* of continued institutionalization, community providers are unable to tailor services to the needs of those currently institutionalized, and residents spend their lives confined to CHDC. This discriminatory system that Defendants have premised on the lifelong institutionalization of

people with disabilities cannot be reconciled with the ADA's mandate that Defendants serve people with disabilities in the most integrated setting.

Defendants further seal residents' fate of lifelong institutionalization through their overall failure to provide adequate care and services at CHDC, which causes serious harm, and even death, to residents. Children, the most vulnerable to the debilitating effects of institutionalization, are denied educational services to which they are entitled and thereby deprived of the opportunity for training and skill-development that would assist them in leading more integrated, productive lives.

Defendants likewise fail to provide CHDC adults with supports and services that would enable them to live as independently as possible. Instead, Defendants subject CHDC residents to extreme forms of physical restraint for unnecessary and prolonged periods of time, as well as harmful and excessive psychiatric medications, in violation of residents' constitutional rights - and in lieu of professional treatment that would maximize residents' capacities for independent living. Defendants also deny CHDC residents necessary medical care, including nutritional and physical supports, and fail to protect residents from avoidable injuries and other harm, in violation of the Constitution. Rather than provide CHDC residents access to treatment that would maximize their capabilities, Defendants expose them to conditions that threaten their lives and safety.

Thus, while confining individuals in a harmful, debilitating facility, Defendants deprive residents the opportunity to live in the most integrated setting appropriate for the residents' needs, thereby ensuring that Defendants' unlawful, harmful, discriminatory system for providing services to individuals with developmental disabilities will continue.

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CERTIFICATE OF SERVICE

I certify that on February 10, 2011, through the Court's CM/ECF system, I caused a copy of the foregoing UNITED STATES' POST-TRIAL BRIEF, to be served to the following:

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APPENDIX

Individual Examples of Deficiencies with CHDC's Medical, Psychiatric, and Psychological Care.

1) **CJ**

The case of CJ illustrates the harm resulting to CHDC residents from inappropriate lapses in communication and judgment by CHDC's psychiatric and medical departments, which culminated in CJ's death. Mikkelsen Tr. 3689:14-3690:4.

A neurology consult for CJ dated October 2006 indicated that she "has had two episodes where she became confused, unable to speak." Although her EEG was normal, the neurologist thought CJ might have been experiencing seizures but was unsure. Mikkelsen Tr. 3690:6-3691:7; US Ex. 791-3. CHDC's consulting psychiatrist noted in February 2007 that CJ was experiencing agitation, possibly resulting from the anticonvulsant Keppra, which she began to receive in late October 2006. Mikkelsen Tr. 3691:10-3692:2; US Ex. 791-3. The consulting psychiatrist recommended decreasing the Keppra, switching to a different anticonvulsant medication, or administering Haldol "to control increased agitation and lability." Mikkelsen Tr. 3692:7-12; US Ex. 791-3. It is inappropriate to introduce an antipsychotic agent to cover agitation produced by medication that has not been proven to be necessary or essential. Mikkelsen Tr. 3692:25-3693:3.

Nothing in CJ's record evidences a discussion among CHDC's consulting psychiatrist, CJ's primary care physicians, or CJ's neurologist regarding the significant agitation and aggression she was experiencing, apparently associated with the antiseizure medication Keppra, or regarding the use of an antipsychotic agent to suppress the suspected effects of the Keppra. Mikkelsen Tr. 3696:8-3697:4, 3712:6-11, 3713:2-7. This is a departure from generally accepted professional standards of care. Mikkelsen Tr. 3696:22-3697:4. This is important because the neurologist was not sure that CJ actually was having seizures and could have addressed the

problem by discontinuing the seizure medication or switching to another medication. Mikkelsen Tr. 3712:12-3713:2.

After recommending the use of Haldol to control agitation caused by Keppra, CHDC's consulting psychiatrist recommended that he next see CJ six to eight weeks later. Mikkelsen Tr. 3693:11-12. In other words, even though CJ was about to have an imminent medication change, the consulting psychiatrist intended to wait several weeks before seeing CJ again. This lapse in treatment following introduction of an antipsychotic agent is contrary to generally accepted standards of care. Mikkelsen Tr. 3693:13-3694-:2. In April 2007, CHDC's consulting psychiatrist confirmed that CJ began receiving Haldol in mid-March 2007 and recommended doubling the Haldol dosage "[i]f the rate of reports of agitation and aggression does not decline by the end of the month." Mikkelsen Tr. 3694:24-3695:7; US Ex. 787. After recommending a doubling of CJ's Haldol, the consulting psychiatrist proposed to see her next in two to three months. This is an unacceptably long period of time. Mikkelsen Tr. 3695:12-16.

CHDC doubled CJ's Haldol dosage on June 4, 2007. Mikkelsen Tr. 3695:23-3696:2; US Ex. 788. On July 14, 2007, CJ was received at the Conway Regional Health System hospital emergency room. She was reportedly holding her head back to keep her airway open and did not want to swallow. Mikkelsen Tr. 3697:5-20; US Ex. 789. The CHDC on-call physician noted that she was in "near torticollis," which is a motor abnormality. This description is consistent with an acute side effect of Haldol, oculogyric crisis. Mikkelsen Tr. 3697:5-24, 3700:10-24; US Ex. 789. On July 17, 2007, CHDC's consulting psychiatrist recommended discontinuing CJ's Haldol in case is it was contributing to the current changes in her condition. Mikkelsen Tr. 3698:25-3700:9; US Ex. 788. Nothing in the record indicates that CHDC's on-call physician, Dr. Stewart, spoke with the consulting psychiatrist about whether CJ's symptoms were related to

the Haldol. Mikkelsen Tr. 3711:11-14. Dr. Stewart did not even know who the consulting psychiatrist was. Mikkelsen Tr. 3711:14-16.

On July 18, 2007, a neurologist at the Conway Regional Health System noted that CJ had experienced a marked decline two weeks prior and was experiencing muscle tissue breakdown consistent with neuroleptic malignant syndrome. Mikkelsen Tr. 3701:9-3704:7; US Ex. 791-4. Neuroleptic malignant syndrome is caused by antipsychotic medications. It starts suddenly, usually after an increase in medication or after a medication has been started. It involves muscular stiffening to the point of the break down and can cause a cascade of physiological events that can end in death. Mikkelsen Tr. 3704:21-3705:20. The CHDC nursing death summary for CJ notes that she had been holding her upper extremities tightly in a fixed position and had undergone x-rays and MRIs to assess this condition. Mikkelsen Tr. 3706:21-3707:12; US Ex. 791-5. This rigidity is an early sign of neuroleptic malignant syndrome. Mikkelsen Tr. 3707:13-18. When reviewing CJ's records during his deposition, CHDC's on-call physician noted that CJ could have been experiencing neuroleptic malignant syndrome. Mikkelsen Tr. 3704:11-20.

By July 19, 2007, CJ's muscular stiffening worsened, and the CHDC on-call physician, who was also the treating physician in the hospital, suspected CJ was experiencing a muscular breakdown. Mikkelsen Tr. 3707:22-3708:5, 3710:22-3711:2; US Ex. 791-5. Apart from receiving intravenous fluids, CJ was not administered the standard treatments that counteract neuroleptic malignant syndrome. Mikkelsen Tr. 3709:25-3710:21. On Monday, July 23, 2007, CJ's legs were stiff and rigid, which is consistent with continued untreated neuroleptic malignant syndrome. Mikkelsen Tr. 3708:13-20, 3709:5-8; US Ex. 791-5. CJ died on the following

Sunday, July 29, 2007, with the cause of death identified as polymyositis, or inflammation of the muscles. Mikkelsen Tr. 3709:10-16; US Ex. 791-5.

CJ died of neuroleptic malignant syndrome caused by the doubling of the Haldol that was administered to suppress the agitation she was experiencing from an anti-seizure medication, even though CHDC's consulting neurologist was not sure that CJ was experiencing seizures. Mikkelsen Tr. 3692:7-12, 3711:3-9, 3712:12-20; US Ex. 791-3. A lack of communication among the treating professionals resulted in conflicting medication orders that gave rise to dangerous side effects, which were not addressed because CHDC's consulting psychiatrist, consulting neurologist, and on-call physician operated in isolation from one another in treating CJ. Mikkelsen Tr. 3712:21-3713:12.

2) **CHL**

At the time of his admission to CHDC, on March 27, 2008, CHL was a nine-year-old boy. US Ex. 897; Holloway Tr. 2541:8-11. CHL's case demonstrates that CHDC subjects individuals to harm from deficient intake assessments, insufficient communication between CHDC staff and the consulting psychiatrist, and inadequate monitoring and management of psychotropic medications.

CHL was receiving psychotropic medications, including lithium and Depakote, upon his admission to CHDC. Holloway Tr. 2543:14-16; Mikkelsen Tr. 3661:5-20; US Exs. 897. Although CHL's admission records indicate that he was receiving lithium for the stated reason of "PSYCH", presumably relating to psychiatry, and that he had a history of adverse reactions to psychotropic medications, he did not receive a psychiatric intake screening or assessment at the time of admission. Mikkelsen Tr. 3660:16-3661:4, 3661:24-3662:6; US Ex. 888. CHL waited five weeks after his admission before his first psychiatric evaluation. Holloway Tr. 2541:12-17;

US Ex. 897. By the time the consulting psychiatrist first saw CHL, he had been subjected to lethal levels of lithium toxicity. Holloway Tr. 2544:7-16.

According to testing done by CHDC, a normal lithium level is "1", and the upper reference limit of lithium is "1.2". Holloway Tr. 2542:8-2542:25; US Ex. 891. At lithium levels near the upper reference range, a person can begin to experience lithium toxicity. Holloway Tr. 2543:1-6. Therefore, particular caution needs to be exercised with lithium, including very careful monitoring. Holloway Tr. 2543:3-6.

The day after CHL was admitted to CHDC, his lithium level was .5. Holloway Tr. 2543:14-24; Mikkelsen Tr. 3662:7-3663:7; US Exs. 890, 897. Five days later, CHL's lithium level had doubled to 1. Holloway Tr. 2543:22-24; Mikkelsen Tr. 3663:8-20; US Exs. 891, 897. It is unusual for a lithium level to increase so much in such a period of time. Mikkelsen Tr. 3663:24-3664:5. Given that CHL's lithium level was increasing exponentially in a short period, it would have been appropriate, as a matter of common sense, to repeat the lithium lab test. Mikkelsen Tr. 3664:14-22, 3664:25-3665:2. CHDC did not conduct further testing and took no steps in response to the doubling of CHL's lithium level. Mikkelsen Tr. 3664:8-13, 3664:23-24.

On April 9, 2008, CHL gagged on his medications, swallowed only with difficulty, and vomited a small amount of matter. Mikkelsen Tr. 3665:3-23; US Ex. 894. Although nausea and vomiting are early signs of lithium toxicity, CHDC staff undertook no clinical response to this episode. Mikkelsen Tr. 3665:24-3666:2, 3666:5-8. Lithium toxicity progresses from nausea to a tremor, to shaking of upper extremities, to unsteadiness of gait. Mikkelsen Tr. 3667:7-11. On May 1, 2008, at 9:00 pm, CHL was admitted to CHDC's infirmary with an unsteady gait and upper respiratory congestion. Mikkelsen Tr. 3666:11-3667:5; US Ex. 901. Staff did not notify the consulting psychiatrist of these potential lithium side effects at the time they were detected.

Holloway Tr. 2544:9-11. In response, the on-call physician ordered that CHL's lithium and Depakote levels be checked then and again in the morning. Mikkelsen Tr. 3667:17-21.

CHDC records dated May 1, 2008, at 10:55 pm, record that Conway Regional Medical Center reported CHL's lithium level was "more than 4." Mikkelsen Tr. 3668:13-18; US Ex. 904. A lithium level as low as 2.5 has the potential of being lethal. Any level above 3 is very serious. Mikkelsen Tr. 3669:3-6. A level of 4 risks death. Mikkelsen Tr. 3668:24-25. CHL's lab results were reported as "more than 4" because the local laboratory's equipment could not record lithium levels exceeding 4. Mikkelsen Tr. 3669:13-18; Parmley Tr. 5477:10-25.

Given his lithium level of "more than 4," CHL required hospital care, including immediate kidney dialysis because toxic levels of lithium can damage the kidney. Mikkelsen Tr. 3669:21-24, 3673:6-3674:8. However, CHDC did not transfer CHL to Conway Regional Medical Center until the following day. Mikkelsen Tr. 3670:11-25; US Ex. 892. Defendants' consultant, Dr. Kraus, testified that he had never had a patient with a lithium level of 4. Kraus Tr. 6385:18. Dr. Kraus testified that he most likely would have immediately hospitalized CHL when learning that CHL's lithium level had reached 4. Kraus Tr. 6386:15-18.

The Conway Regional Medical Center admission note for CHL states that "[H]e is admitted with decreased level of consciousness. He is comatose." Mikkelsen Tr. 3671:16-17; US. Ex. 892 at 2. The Conway Regional Medical Center determined that CHL needed to be sent by air-flight to the Pediatric Intensive Care Unit of the Arkansas Children's Hospital to receive dialysis. Mikkelsen Tr. 3671:5-3672:1; U.S. 892 at 2. Arkansas Children's Hospital subsequently recorded CHL's lithium level at 6.8. Mikkelsen Tr. 3673:3-4; Ex. 895. CHL required two rounds of hemodialysis to lower his lithium level below 3. Mikkelsen Tr. 3672:6-7. CHL unquestionably was close to dying from lithium toxicity. Mikkelsen Tr. 3674:15-17.

Manifestations of lithium toxicity include meal refusals, lethargy, increased thirst, increased urination, tremors, seizures, coma, renal failure, and death. Holloway Tr. 2543:7-11, 2544:3-8. The consulting psychiatrist noted that, early in CHL's stay at CHDC, CHL was having problems consistent with lithium side effects. Holloway Tr. 2543:19-2544:3; Mikkelsen Tr. 3676:18-3677:4; US Ex. 897. CHL was excessively thirsty. Holloway Tr. 2544:3-4; Mikkelsen Tr. 3677:14-20; US Ex 897. He was not eating well and had 14 reports of meal refusals. Holloway Tr. 2544:4-5; Mikkelsen Tr. 3677:22; US Ex. 897. He was lethargic and sleeping a great deal, day and night. Holloway Tr. 2544:5-6; Mikkelsen Tr. 3677:21-22; US Ex. 897. These symptoms are consistent with lithium toxicity. Mikkelsen Tr. 3677:25-3678:2; US Ex. 897.

Staff did not notify the consulting psychiatrist of these potential lithium side effects at the time they were detected. Holloway Tr. 2544:9-11. A critical care medicine note from the Arkansas Children's Hospital indicates that CHL was experiencing mental status changes for at least two days before CHL was admitted to CHDC's infirmary. Mikkelsen Tr. 3672:21-22; US Ex. 895. Although CHL would have had to have been exhibiting additional signs of lithium toxicity before he was admitted to the CHDC infirmary, his condition was allowed to deteriorate severely before CHDC intervened. Mikkelsen Tr. 3678:22-3679:1. Neither the consulting psychiatrist, nor any other psychiatrist, was involved in CHL's care and treatment until after CHL's lithium level rose to greater than 4.0, CHL required hospitalization, CHL received dialysis because of lithium toxicity, and CHL returned to CHDC. Holloway Tr. 2544:11-2545:11; Ex. 897.

3) **TN**

TN's case demonstrates that CHDC subjects individuals to harm from inadequate psychiatric care and inadequate monitoring of side effects from psychotropic medications.

CHDC's consulting psychiatrist first saw TN when he was approximately 17 years old, in the 1990s. Mikkelsen Tr. 3736:23-3737:14. The consulting psychiatrist subjected TN to two trials of antidepressants. Mikkelsen Tr. 3739:6-3740:2. Administering antidepressants to someone who has a bipolar disorder risks precipitating a manic episode and both trials triggered apparent manic episodes in TN. Mikkelsen Tr. 3739:6-3740:6. The consulting psychiatrist subjected TN to the second trial of antidepressants after diagnosing TN with bipolar disorder. Mikkelsen Tr. 3739:8-3740:2.

The consulting psychiatrist administered the medication Depakote to TN because it was thought that TN had some behaviors related to seizures, although TN was never diagnosed with a seizure disorder. Mikkelsen Tr. 3739:12-17. A side effect of Depakote is a decrease in the platelet count, a condition called thrombocytopenia. Mikkelsen Tr. 3740:12-18. CHDC's consulting psychiatrist and other health providers did not communicate regarding the health risks that Depakote presented to TN and whether those risks warranted continuing to administer Depakote to TN. Mikkelsen Tr. 3756:6-12. Approximately in 2000, CHDC's consulting psychiatrist determined that the Depakote TN was receiving was not effective and that he was going to discontinue the Depakote. Mikkelsen Tr. 3740:24-3741:3. Subsequently, the consulting psychiatrist referenced a previous note indicating that TN's Depakote may have been used for behaviors having some seizure component, and he elected to continue using the Depakote even though he had determined that the Depakote was not of significant help and was causing TN's platelet level to drop. Mikkelsen Tr. 3741:4-11, 3742:19-23, 3746:21-23; US Ex. 809.

CHDC's consulting psychiatrist continued to administer Depakote to TN even after TN's platelet levels dropped to the point where TN was hospitalized in early May 2009 and required blood transfusions. Mikkelsen Tr. 3743:14-3752:18; US Ex. 809; US Ex. 810-2; US Ex. 905; US Ex. 906; US Ex. 907. At the time TN received blood transfusions, he was at great risk. He could have experienced spontaneous bleeding. Mikkelsen Tr. 3753:17-21. If something had precipitated bleeding in TN, it may have been impossible to stop the bleeding. Mikkelsen Tr. 3753:21-3754:2.

CHDC's consulting psychiatrist was not informed of what happened to TN while TN was in the hospital and did not see TN until approximately two weeks following TN's discharge from the hospital. Mikkelsen Tr. 3754:9-10; US Ex. 809. The consulting psychiatrist was not aware of why TN's Depakote dosage had changed or when that occurred. His records simply state that "[h]is Depakote level was reduced at some point since his last visit. It is not clear exactly when and may have been while he was in the hospital or infirmary. He has had issues in the past with thrombocytopenia . . . . He is having no definite side effects otherwise from his psychiatric medication." Mikkelsen Tr. 3754:20-25; US Ex. 809. During this time, there is no evidence that the Depakote was helpful to TN. Mikkelsen Tr. 3750:10-15.

4) **TM**

TM's case demonstrates that CHDC subjects individuals to risk of harm from inadequate monitoring of side effects from psychotropic medications.

When Dr. Holloway observed TM at CHDC during a pre-trial tour, she repeatedly observed bilateral tremulousness of both his upper extremities. Holloway Tr. 2553:12-22, 2555:2-23. She also repeatedly observed that his gait was unsteady. Holloway Tr. 2554:2-5, 2554:24-2555:1. She also observed his body arch, his neck writhe back, and him experience a

muscle tightening in a torsion-like movement. Holloway Tr. 2554:10-16. She also observed that he had a dazed look. Holloway Tr. 2554:23. These movements are consistent with medication side effects, such as a dystonic reaction, and seizure activity. Holloway Tr. 2556:8-21. TM has a history of a seizure disorder. Holloway Tr. 2557:23-24. These types of movements should be assessed by the consulting psychiatrist, Holloway Tr. 2556:13-23, and the primary care physician, Holloway Tr. 2557:21-24. Instead, CHDC direct care staff seemed unaware of the need for further assessment. The CHDC staff dismissed the symptoms and told Dr. Holloway that these movements were associated with TM being cold or afraid of strangers. Holloway Tr. 2557:2-4.

5) **ACJ**

ACJ's case illustrates that CHDC places individuals at risk of harm from unlawful deficiencies in psychiatric care including inappropriate diagnosis, insufficient data collection and analysis, inadequate monitoring of side effects of psychotropic medications, and improper standards for review of continued psychotropic medication use.

Staff gave ACJ a diagnosis of "organic mood disorder," a diagnosis that is unrecognized and nonexistent in the field of psychiatry. Holloway Tr. 2582:11-18. ACJ has been identified as having 211 problem behaviors. Holloway Tr. 2583:5-21. Data regarding ACJ are provided in an aggregate form that does not enable a clinician to identify the specific causes of behavioral problems or how this individual is responding to particular interventions. Holloway Tr. 2583:6-2584:5. ACJ's individual program plan indicates that she is receiving five different psychotropic medications. Holloway Tr. 2584:6-15. Yet, the program plan provides only a generic description of the medications' side effects and does not inform staff of the side effects they should be monitoring. Holloway Tr. 2584:16-2585:11. The program plan's taper criteria for

reduction of psychotropic medications states, "When [ACJ] has reduced all instances of aggression, self-injury, agitation/mania, and pica to a combined total of five or less episodes per month for 10 of 12 months, then the ID team will meet to discuss her progress and further treatment options." Holloway Tr. 2585:12-25; US Ex. 877-2.

6) **SS**

The case of SS illustrates that CHDC places individuals at risk of harm from staff's failure to adhere to generally accepted professional standards in prescribing psychotropic medications.

Throughout most of the 1990s, SS had experienced great stability on the medication Mellaril. Mikkelsen Tr. 3758:25-3759:2. CHDC's consulting psychiatrist switched SS from Mellaril to Zyprexa because of the guardian's wishes, even though the consulting psychiatrist concluded that the Zyprexa caused SS to experience glucose problems associated with diabetes mellitus and that there had not been in a major change in SS's overall condition on the Mellaril. Mikkelsen Tr. 3759:18-3760:3. In fact, CHDC's data indicate that SS's acts of aggression had decreased by 80 percent while she was receiving the Mellaril. Mikkelsen Tr. 3760:12-21. CHDC subjected SS to dangerous medication side effects, against the treating professional's judgment, due to SS's guardian's wishes, even though the original medication was more effective in treating SS's behavior. Mikkelsen Tr. 3757:2-15; US Ex. 816.

7) **TC**

TC is about 9 years old. Matson Tr. 1150-2-5. TC's case illustrates that CHDC places individuals at risk of harm due to inadequate psychiatric care and monitoring of side effects from psychotropic medications; long delays between the development and implementation of behavioral plans; and staff's lack of understanding as to how to identify clear target behaviors,

conduct and utilize functional assessments, collect reliable data, and develop effective behavioral treatment programs. Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; Mikkelsen Tr. 3736:8-11; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17.

TC was admitted to CHDC on August 10, 2007, at the age of six. Mikkelsen Tr. 3720:4-9; US Ex. 803. At the time, TC was diagnosed with autism but no other psychiatric disorders. Mikkelsen Tr. 3720:15-20. Upon TC's admission, he was receiving three medications for psychiatric reasons: risperidone, clonodine, and thorazine. Mikkelsen Tr. 3721:1-9; US Ex. 803. The CHDC consulting psychiatrist acknowledged in his screening note that risperidone "at least, has indication for use of autistic disorder" and recommended decreasing and eventually eliminating the other antipsychotic medication TC was receiving, thorazine, which is more sedating that risperidone. Mikkelsen Tr. 3721:13-24, 3724:16, 3730:14-16; US Ex. 803. On April 7, 2008, after speaking with TC's grandmother, CHDC's consulting psychiatrist recommended tapering and ultimately discontinuing the risperidone. Mikkelsen Tr. 3723:24-3724:6; US Ex. 805. This is the opposite direction from the consulting psychiatrist's original plan, which had been clinically supported. Mikkelsen Tr. 3724:10.

On October 21, 2008, CHDC's consulting psychiatrist noted that TC's Thorazine dosage had increased, and he recommended increasing it further. Mikkelsen Tr. 3726:20-3727:16; US Ex. 805. He also noted that TC's dosage of risperidone had stopped completely. He stated that, "[i]f the team members, especially the family, want the risperidone restarted, that would be understandable." Mikkelsen Tr. 3726:10-23; US Ex. 805. On November 20, 2008, CHDC's consulting psychiatrist noted that the risperidone had been restarted. Mikkelsen Tr. 3727:4-11; US Ex. 805.

On January 28, 2009, CHDC'S consulting psychiatrist noted that TC's grandmother was concerned that Thorazine was causing TC weight loss, but he discounts this possibility. Mikkelsen Tr. 3727:20-24; US Ex. 805. In fact, TC had lost more than 20 percent of his body weight from eleven months earlier. Mikkelsen Tr. 3728:2-12; US Ex. 805. In his May 15, 2009 consultation note, CHDC's consulting psychiatrist stated that TC was "having no known side effects from his psychotropic medication." Mikkelsen Tr. 3731:6-8. He noted that TC had been more aggressive and had more tantrums and identified the increase as "possibly situational." Mikkelsen Tr. 3729:4-9, 3733:10-14; US Exs. 805, 806. In response, the consulting psychiatrist recommended increasing the dosages of Thorazine or the risperidone given to TC. He stated that "[m]y preference would be to increase the Thorazine, but last year the grandmother wanted to reduced back down for reasons that were clear only to her herself." Mikkelsen Tr. 3729:25-3730-5; US Ex. 805.

Eleven days later, TC's psych examiner reported that staff had observed TC experiencing shaking, an increase in agitation and aggression, and a loss of appetite since TC's Thorazine was increased. Mikkelsen Tr. 3732:18-3733:3; US Ex. 806. On June 5, 2009, members of TC's treatment team held a special staffing to discuss the increase in Thorazine. Mikkelsen Tr. 3731:10-16; US Ex. 806. CHDC's consulting psychiatrist did not participate in this meeting and was not notified that it would occur. Mikkelsen Tr. 3733:15-3734:1.

In a June 25, 2009 special staffing, TC's team concluded that the cause of TC's behavior was not psychiatric, but rather the cause of his inappropriate behavior is thought to be because he "is trying to obtain something tangible or escape from a nonpreferred activity. He may also be venting frustration over not obtaining what he desires." Mikkelsen Tr. 3734:17-23, 3735:1-4; US Ex. 807. The only psychiatric diagnosis TC had was autistic disorder. Mikkelsen Tr.

3730:21-24. CHDC's consulting psychiatrist does not provide a clinical justification for the use of Thorazine. In fact, there is no clinical justification for the use of Thorazine in a child with autism. Mikkelsen Tr. 3731:3-5. CHDC administered psychotropic medications to TC to suppress behaviors that have been identified as being present on a learned behavioral basis. Mikkelsen Tr. 3736:8-11. Moreover, although staff did not adequately identify the causes for his behaviors before utilizing medications, the taper criteria for TC's medications require "one or less behavior reports for tantrum behavior for 10 or 12 months," which basically cannot be met by any nine year-old boy. Matson Tr. 1150:2-1151:3.

In addition to the inadequate medication practices, TC's behavioral planning is insufficient. TC's plan was developed on September 8, 2008, revised January 13, 2009, and not implemented April 20, 2009. Manikam Tr. 3126:19-3127:5. TC's functional assessment is not adequate. Numerous behaviors are being tracked without clear differentiation between behaviors and functions of behaviors. TC engages in head-butting, kicking and scratching. TC eats inedible objects, but he has no diagnosis of pica. He also goes out of bounds, but staff erroneously believe behavioral interventions do not work on out of bounds behavior, so they provide no specific intervention for this behavior. Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17.

Psychology staff have listed a variety of possible triggers for his behaviors in different parts of his treatment program. Without a coherent assessment of TC's behaviors, staff appear to be ignoring or inconsistently applying interventions. For instance, staff identified family visits, especially by TC's father, as triggers for TC's challenging behaviors, but his behavioral treatment program does not specifically address this environmental issue. Other possible triggers for TC's challenging behaviors include pain, headaches, overcrowding, or noise, but TC's safety plan does

not address any of those medical or environmental triggers. More generally, staff have not made an adequate effort to clearly delineate which triggers apply to particular behaviors (i.e. the functional assessment does not differentiate between multiple challenging behaviors). Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17; US Exs. 567 through 570.

Some of TC's behavioral interventions are highly restrictive, if not outright dangerous. For instance, TC has a helmet that is used in the event of aggression. Staff claim that TC's helmet helps stop him from head butting and biting, though the mechanism is odd and unclear. Sometimes, during these tantrums, he will flail and struggle. Yet, in the face of active physical resistance, staff are supposed to try to put a helmet on his head. CHDC's position seems to be that the helmet somehow calms TC, so it is not even considered a restraint. TC also gets placed in a papoose board even though this highly restrictive measure is not included expressly in his behavioral program. While state witnesses claim TC has been doing very well at CHDC, their own data suggests the situation is more problematic. According to one "special staffing" record, TC was placed in a papoose board at least three times around June 2009, apparently after staff removed mechanical restraints from his formal program. US Exs. 567 through 570; Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17.

The intervention process makes little sense from a behavioral perspective. Staff apply TC's helmet on a "contingent basis" which means that sometimes staff may use it, sometimes they may not. This is not an appropriate way to try to diminish behavior, because it creates what is referred to as a "variable schedule of reinforcement." In other words, sometimes there is a consequence for behavior, sometimes there is not. If the helmet was really being used as a

relatively benign calming device, the schedule for use would have to be quite different if staff wanted to reinforce appropriate behavior. Moreover, the target behaviors warranting use of the helmet are poorly defined, again clouding whatever reinforcement effect the helmet may be having. Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17.

The standard for when interventions may be used on TC are vague and incoherent. When asked what to do when TC has a tantrum, psychology staff could not articulate exactly which of the various interventions described in different documents should actually be used by direct care staff. Adams Tr. 1796:16-1817:24; cf. Cooper Tr. 2475:7-2479:17. According to one of the psychology examiners, TC's helmet is supposed to be used only if he attempts to head butt or bite. However, TC's safety plan itself indicates that restraints may be used whenever there is aggression and self-injurious behavior (both of which are poorly defined). TC's positive behavior support program focuses upon increasing communication skills. The positive behavior support program does not, however, provide staff with clear guidance on when staff are supposed to use communication interventions instead of restraints. Also, the positive behavior support plan does not adequately cover some of TC's challenging behaviors at all, such as his out of bounds behavior and a tendency to grab food and drink. TC's strategy, ironically, may reinforce problem behaviors, because it calls for "increasing [TC's] engagement in leisure activities" when he exhibits challenging behaviors. In other words, the more TC acts out, the more access he gets to leisure activities. US Exs. 567 through 570; Matson Tr. 1149:17-1153:13; Manikam Tr. 3126:19-3132:7; *see also* Adams Tr. 1796:16-1817:24; Cooper Tr. 2475:7-2479:17.

Notably, CHDC staff indirectly confirmed much of the United States' expert opinion regarding TC. Adams Tr. 1797:12-24; Cooper Tr. 2475:7-2479:17. Ms. Adams, TC's

psychological examiner, picked TC's case "to go through with Dr. Matson and Dr. Manikam during" their inspection. In her testimony, Ms. Adams admitted she could not recall any inaccuracies with Dr. Matson and Manikam's descriptions of TC's deficient care, as noted in their reports and elaborated on at trial.

8) **ZS**

ZS is 12 years old. Matson Tr. 1164:14-17. ZS's case illustrates that CHDC places residents in harm's way due to CHDC's unreliable assessments and data collection, disorganized treatment process, overuse of restraints, and staff's lack of familiarity with principles of applied behavioral analysis. US Exs. 577, 656; Matson Tr. 1164:11-1167:18, 1171:23-1173:19; Manikam Tr. 3117:1-3119:7; *see also* Adams Tr. 1763:18-1765:3, 1847:12-19.

Although the ICAP is not an appropriate functional or cognitive assessment tool, ZS's functional assessment is basically his ICAP results. ZS's functional assessment is too vague to provide guidance to staff on how to manage his behaviors. ZS refuses to engage in activities, but there is no functional assessment of this challenging behavior at all. ZS's behavioral interventions require that when he refuses to do something, staff are supposed to continue forcing him to participate in the activity. Without a clear understanding of the functions of his behavior, a forceful response from staff can exacerbate his behaviors. Matson Tr. 1164:11-1167:16, 1171:23-1173:19; Manikam Tr. 3117:1-3119:7.

After ZS came in to CHDC, staff diagnosed him as having anxiety and autism. Matson Tr. 1164:11-1167:16, 1171:23-1173:19; *see also* Adams Tr. 1764:5-10. As a result, staff placed ZS on Strattera and Abilify, apparently because of his psychiatric disorders. Adams Tr. 1764:5-10. Yet, his medication taper criteria focus on aggression, not on symptoms of his anxiety

diagnosis. The taper criteria for his medication require that ZS go "ten months without one incident of aggression," which is a standard that likely can never be met. Matson Tr. 1166:13-24

ZS is also on a papoose board. A staff member "stepped on his face and put him in a papoose board" in a confirmed incident of abuse and maltreatment. Adams Tr. 1847:12-19. But even after this incident, his psychological examiner made no changes to his behavioral plan and continued use of the papoose board. Adams Tr. 1847:12-19. Indeed, there was no evidence that staff even considered the abuse incident in reassessing the appropriateness of his plan.

While staff readily use mechanical and possibly chemical restraints on ZS, they have not developed appropriate replacement behaviors as a behavioral alternative to restraints. Matson Tr. 1165:13-14; *cf.* Adams Tr. 1763:18-1765:3, 1847:12-19. Moreover, ZS's release criteria for his papoose board illustrate problems with restraint safeguards and staff's lack of understanding of applied behavioral analysis. Matson Tr. 1164:11-1167:16, 1171:23-1173:19; Manikam Tr. 3117:1-3119:7; *see also* Adams Tr. 1763:18-1765:3, 1847:12-19. ZS's release criteria are not based on resolution of the behavior that resulted in the restraint use. Rather, restraints are to be used for a period of time even *after* ZS becomes calm. Manikam Tr. 3117:1-3119:7. In terms of reinforcement, this type of approach can be confusing to the subject of the restraint, and can cause someone with developmental disabilities to become frustrated. In other words, if staff restrain someone even after he exhibits the behavior desired (calmness), they may actually exacerbate challenging behaviors.

ZS' case also illustrates how CHDC violates the rights of residents to live in the most integrated setting appropriate to their individual needs. CHDC houses ZS in unit 23 Birch with 6 other residents. Although other residents of 23 Birch have been classified as having profound

mental retardation, ZS is the only individual in 23 Birch with mild mental retardation. Adams Tr. 1763:18-1765:3.

9) **LW**

LW is a young child. Adams Tr. 1839:8-1848:4. LW's case illustrates the harm posed to CHDC residents from long delays in the development and implementation of behavior programs, unreliable assessments and data collection, disorganized treatment process, staff's lack of familiarity with principles of applied behavioral analysis, and inadequate safeguards on the use of restrictive measures. US Ex. 580; Manikam 3142:6-3148:4; *see also* Adams Tr. 1839:8-1848:4.

LW's target behavior is tantrums, but the target behavior is not clearly defined. For LW, "tantrums" supposedly include a range of behaviors from self-injury to property destruction to going out of bounds. His assessments and interventions do not differentiate between all of these different behaviors. Manikam 3142:6-3148:4; *see also* Adams Tr. 1839:8-1848:4. As with many other cases at CHDC, there is no alignment between different pieces of LW's behavioral intervention program. Manikam 3142:6-3148:4; *see also* Adams Tr. 1839:8-1848:4. The assessments used by CHDC say different things about the functions of behavior, and interventions do not align with the assessments or each other.

LW wears a hearing aid and sometimes uses sign language. LW's positive behavior support plan discusses providing LW with ways to help him communicate his desires. CHDC does not, however, have anyone trained as a sign language interpreter who can interpret for a deaf resident like LW. LW's positive behavior support plan provides for teaching staff 12 manual signs only *after* LW learns the manual signs first. Manikam 3142:6-3148:4; *see also* Adams Tr. 1839:8-1848:4. Dr. Reddig, CHDC's chief psychologist, indirectly admits that

training resident on signs without training the staff as well is pointless. Reddig Tr. 2034:14-25. In other words, even though communication issues are likely associated with LW's behaviors, CHDC has not developed programs that could actually help LW communicate better with staff and function more independently.

LW has a safety plan for his tantrums. Under the plan, staff may use "separation to allow calming." Adams Tr. 1839:8-1848:4. This means that staff are supposed to move LW to a quiet area, but they are not supposed to bar him from leaving. However, LW's examiner admits that the triggers for his safety plan are so vaguely worded, staff could misinterpret the provision for "separation to allow calming" and apply it more restrictively. Adams Tr. 1839:8-1848:4. In effect, staff can use seclusion-like restrictive measures on LW, for which there no tracking measures or similar safeguards. CHDC staff also use a "soft shell helmet" on LW to deal with head-butting behavior, but his safety plan does not provide for the use of this restrictive measure. Manikam Tr. 3146:21-3147:18. Moreover, LW's program date was July 28, 2008, but the implementation date was not until May 28, 2009. Manikam Tr. 3142:6-3148:4.

10) **CA**

CA is 18 years old. US Ex. SM-6. CA’s case illustrates that CHDC exposes individuals to risk of harm from lack of treatment due to the long delay between the development and implementation of behavioral plans. US Ex. SM-6. Although staff considered CA’s behaviors severe enough to require the papoose board as a restrictive measure, it took nearly seven months to implement CA’s safety plan. Murphy Tr. 4919:4-21.

11) **SA**

SA is 15 years old. Manikam Tr. 3085:1-3. SA’s case illustrates that CHDC subjects individuals to risk of harm from the staff's lack of understanding as to how to identify clear target

behaviors, conduct and utilize functional assessments, collect reliable data, and develop effective behavioral treatment programs. *See generally* US Ex. 561; Matson Tr. 1136:25-1142:1, 1143:25-1145:1; Manikam Tr. 3084:11-3098:16.

CHDC's description of SA's behavior and diagnoses are confusing, vague, and inconsistent with SA's alleged assessments. For instance, the definition used for SA's self-injurious behavior is so broad and subjective that it cannot serve as a reliable basis for treatment and covers injuries that are probably not self-injurious behaviors at all. SA's functional assessment fails to clearly define the functions for her multiple target behaviors. Staff do not track identified functions of behavior, such as constipation or menstrual discomfort, and do not ensure inter-rater reliability for events that are tracked. Staff do not engage in basic data collection and graphing of data to clarify the functions of her behavior and improve treatment. Although one of SA's main target behaviors is "aggression," staff do not assess the fact that SA repeatedly engages in aggression with specific individuals. Matson Tr. 1136:25-1142:1; Manikam Tr. 3084:11-3098:16.

Instead of providing appropriate treatment, CHDC staff are using restraints, including a papoose board and chemical restraints, to manage SA's behavior. Staff also use one to one supervision on SA. Such additional staff supervision is not a substitute an effective behavioral program; rather, it is largely an administrative response to poorly managed behavior. Matson Tr. 1143:25-1145:1; Manikam Tr. 3084:11-3098:16. CHDC further exposed SA to risk of harm from lack of treatment due to an eight-month delay between the development and implementation of her safety plan, even as SA was supposedly engaged in very dangerous behavior. Manikam Tr. 3085:1-3, 3085:18-3086:4.

Even when staff found problems in SA's treatment, CHDC did not address the source of those problems. For instance, understaffing contributed to staff giving the wrong dose of medication to SA, but when CHDC administrators devised corrective action, they just required that the staff review documents describing patient rights instead of addressing the staffing problem that was alleged on that unit. Manikam Tr. 3097:3-3098:16.

12) **DB**

DB is a child. Matson Tr. 1149:14-16. DB's case illustrates that CHDC places individuals at risk of harm from staff's lack of understanding as to how to assess individuals with developmental disabilities, identify clear target behaviors, conduct and utilize functional assessments, collect reliable data, develop effective behavioral treatment programs, and apply proper taper standards and safeguards when utilizing restraints. *See* Matson Tr. 1147:19-1149:16; US Ex. 566; *see also* Adams Tr. 1831:2-1839:7.

DB does not have an adequate functional assessment. Matson Tr. 1147:19-1149:16. He has four targeted behaviors, but his assessments do not clearly differentiate between behaviors. Matson Tr. 1147:19-1149:16. DB's inappropriate behaviors supposedly occur frequently "during transitions." DB also supposedly cannot tolerate "loud noisy environments" and "environments that present with tangible items on the walls or shelves." US Ex. 566, Adams Tr. 1831:2-1839:7. DB has communication problems, and staff are supposedly trying to teach him to better communicate. Yet his safety plan provides for putting DB on a papoose board in a quiet place, without informing DB that "his behavior is leading to possible restraint use." Adams Tr. 1831:2-1839:7. So basically, instead of addressing the environmental and communication factors, staff are being instructed to place DB, without warning, on a papoose board in the quiet environment he prefers if he engages in negative behavior. DB's case also shows that CHDC staff do not

understand how to utilize applied behavioral approaches as a less restrictive alternative to restraints, as DB does not have any "replacement behaviors" as part of his program. Matson Tr. 1147:19-1149:16.

During the pendency of this litigation, CHDC staff discontinued DB's safety plan. He supposedly no longer needed a safety plan because of improvements in his behaviors and restraint use. However, his records show that he either had not actually met the taper standard for the termination of his safety plan, or staff made changes to his behavioral programming without clear analysis of his behavioral history. In fact, DB had been placed in emergency restraints four times in December 2008 – January 2009. Even though his psychology examiner apparently attributes improvements in DB's behavior to a successful behavioral program, she admits he has had an increase in medication. As with other cases at CHDC, staff fail to systemically analyze and identify the effect of various treatment approaches on behaviors before arbitrarily changing treatment. *See* Adams Tr. 1831:2-1839:7.

13) **HB**

HB is 13 years old. Manikam Tr. 3123:9-14. HB's case illustrates that CHDC subjects individuals to risk of harm from long delays between the development and implementation of behavioral plans and staff's lack of understanding as to how to assess individuals with developmental disabilities, identify clear target behaviors, conduct and utilize functional assessments, collect reliable data, and develop effective behavioral treatment programs. Manikam Tr. 3123:3-3126:18.

HB's June 18, 2008 safety plan has an October 10, 2008 implementation date. In many respects, HB's written behavioral program has not changed over time despite clinically significant changes in behavior and condition. His 2008 and 2009 programs contain identical

provisions. His safety plans from separate years use the same language about how his behaviors have dramatically decreased in the previous year, but the data on his behaviors is not nearly so clear, which could suggest the language is rote. Manikam Tr. 3123:3-3126:18; *see also* Adams Tr. 1817:25-1831:1.

HB has tantrums and goes out of bounds. His safety plan unhelpfully describes a host of different behaviors as evidence of tantrums. HB has a positive behavior support plan that includes tantrums as a target behavior, but which does not provide any interventions for that behavior. Manikam Tr. 3123:3-3126:18; *see also* Adams Tr. 1817:25-1831:1. A number of behavioral antecedents are asserted but then ignored in his plans. His strategy addresses out of bounds behavior, although it is not clear how that is defined or distinguished from some of the behaviors associated with his tantrums. The data supporting HB's treatment program is problematic.

Even as his different safety plans repeatedly note that his behaviors have improved, his strategy indicates that from April 2008-February 2009, he had 91 behavior reports for tantrums and 3 behavior reports for out of bounds behavior. Adams Tr. 1826:2-1827:11. This appears to conflict with the psychology staff's insistence that his behaviors have improved so much, he no longer needs a safety plan. Additionally, it is telling that his psychology examiner could not explain why his behaviors remain a basis for keeping him institutionalized if HB's behaviors have really improved drastically. *See* Adams Tr. 1823:4-1824:15.

HB's behavioral program includes "programmatic therapeutic holds." Manikam Tr. 3123:3-3126:18; *see also* Adams Tr. 1817:25-1831:1. This euphemism includes putting HB prone on a mat with his arms pinned above his head by one staff and legs pinned by another staff. Even though he no longer has a safety plan at all, restrictive holds may still be used as an

emergency measure. In their various data collection and administrative procedures, CHDC staff do not distinguish between the levels of restrictiveness of different types of hold, so relatively less restrictive one-person, standing hold is classified the same the significantly more restrictive prone hold. Whether someone is using four, three, or two-point restraints is clinically important information. Without differentiation, the treatment approaches are less likely to be individualized. Manikam Tr. 3123:3-3126:18; *see also* Adams Tr. 1817:25-1831:1.

14) **MB**

MB is nine years old. Manikam Tr. 3099:3-6. MB's case illustrates how CHDC places individuals at risk of harm from failing to clearly identify target behaviors and then develop consistent treatment responses. Manikam Tr. 3098:17-3104:14; US Ex. 562.

CHDC staff are focusing only on addressing MB's climbing behavior, but MB also mouths or ingests non-food items. However, she has not been given a diagnosis of pica, staff have not carefully assessed this mouthing behavior to determine whether MB has pica, and CHDC has not developed strategies to address her mouthing or ingestion of non-food items. Manikam Tr. 3098:17-3104:14.

MB's case also shows how CHDC staff ignore entire categories of behavior which could benefit from psychological assessment and treatment. Some of the information in her chart suggests that MB's nutritional issues (eating or drinking too rapidly) are behavioral in origin. Because psychology staff are not familiar with such concepts, they are not evaluating MB for appropriate behavioral interventions. Instead, staff have placed MB on a modified diet (chopped food), even though she was capable of eating a normal diet when living in the community. Manikam Tr. 3098:17-3104:14.

15) **TB**

TB's case is another example of CHDC's unreliable assessments and data collection, disorganized treatment process, and lack of familiarity with principles of applied behavioral analysis. Manikam Tr. 3148:5-3149:1.

His functional assessments and behavioral interventions are inconsistent. The interventions being adopted have little to do with the assessed function of his behaviors. CHDC staff also failed to modify TB's behavioral program on a timely basis in accordance with the set taper criteria. Although TB actually met the standard for taper of his restrictive program by not exhibiting pica behavior for ten months, staff made no revision to his plan. Manikam Tr. 3148:5-3149:1.

16) **CC (a.k.a. "DC")**

CC's case again illustrates the risk of harm to CHDC residents caused by the problems with CHDC's unreliable assessments, disorganized treatment process, and lack of familiarity with principles of applied behavioral analysis. The target behavior for his plan was "aggression." His medical records however, indicate that he had another behavior that was not addressed at all – rubbing and picking at his gums. Instead of developing a behavioral intervention and making every effort to address possible pain, staff decided to consider pulling CC's teeth instead. Manikam 3109:12-3111:4; US Exs. 30-12, 687.

17) **RLC (adult referenced as RC at trial)**

RC's case illustrates the problems with CHDC's unreliable assessments and data collection, disorganized treatment process, and lack of familiarity with principles of applied behavioral analysis. RC's challenging behavior involves repeated placement of his hand in his mouth. For purposes of intervention and data collection, staff have defined RC's target behaviors

as those mouthing behaviors that "result in restrictive interventions." This circular definition completely omits less severe behaviors that can escalate to requiring restrictive interventions. By the time staff intervenes because his mouthing is causing harm, it is too late. Manikam Tr. 3149:2-3150:5.

18) **RC (child)**

RC is 15 years old. Manikam Tr. 3132:17-22. RC's case illustrates risk of harm to CHDC residents as a result of the problems with CHDC's unreliable assessments, disorganized treatment process, and lack of familiarity with principles of applied behavioral analysis. Matson Tr. 1153:18-1160:14; Manikam Tr. 3132:8-3142:5; US Ex. 571.

RC has a history of physical and sexual abuse, and has a very strong reaction when RC feels someone is trying to control her. Manikam Tr. 3132:8-3133:10. RC's challenging behaviors include aggression and bedwetting. RC has been diagnosed with "reactive attachment disorder" and Asperger's. Matson Tr. 1153:18-1160:14. Asperger's is a very unusual diagnosis for someone in this population. Asperger's is part of the autism spectrum of disorders, but is typically diagnosed in people with IQ's in the 110-140 range. RC is mildly retarded. RC's functional assessment is inadequate, and her target behaviors are poorly defined. Her behaviors are relatively infrequent; yet staff use unreliable direct observations to analyze her behavior even though such observations are not likely to capture the event being monitored. Matson Tr. 1153:18-1160:14.

RC's interventions are inadequate. Matson Tr. 1153:18-1160:14; Manikam Tr. 3132:8-3142:5. RC's "positive behavior support plan" requires that she earn "95 percent of points possible per month" under the point "reinforcement system for seven to eight months." Matson Tr. 1153:18-1160:14. The standard is arbitrary and is not data driven. CHDC is using the same

standard point system for her that their own staff admit has not worked in the past when used for other residents. The generic approach does not address many of the environmental triggers for her aggression; nor does it address communication issues. Her behavioral program does not address at all one identified habilitation need – bedwetting. Matson Tr. 1153:18-1160:14; Manikam Tr. 3132:8-3142:5.

Her treatment program is very similar to the programs used for other residents, and reflects many of the same problems. Matson Tr. 1153:18-1160:14; Manikam Tr. 3132:8-3142:5. Staff appear not to understand principles of applied behavioral analysis. She has no replacement behaviors. There is little indication that psychiatry and psychology staff are working together to distinguish behaviors that should be treated with medications versus psychological approaches. RC's standard for obtaining points and privileges is "self-control," which is not a clear and workable operational definition. In other words, staff can impose restrictive measures, including both the papoose board and "therapeutic holds," on RC if she fails to meet a vague behavioral standard. Matson Tr. 1153:18-1160:14; Manikam Tr. 3132:8-3142:5.

19) **JD**

JD's case illustrates the risk of harm posed by CHDC's problems with unreliable data collection, disorganized treatment process, and psychology staff's failure to appropriately treat and monitor residents' behaviors and the effects of their medications. Warren Tr. 4787:16-4791:25. CHDC staff continually increased JD's tegretol, which was originally prescribed for his seizures but then apparently started being used for behaviors. Even as CHDC's psychiatrist was increasing tegretol levels to address poorly defined target behaviors, psychology staff were generating data that indicated improvements in his behaviors. In other words, medical staff increased his medications because they may have thought he was getting worse based on their

data, while his psychology staff apparently thought he was getting better. *See generally* Warren Tr. 4787:16-4791:25.

20) **KF**

KF's case illustrates the problems with CHDC's psychology staff's lack of familiarity with applied behavioral analysis. The psychology staff tried to develop and implement a function-based treatment plan without having first conducted an adequate functional analysis. More specifically, they are treating "aggression" without a clear definition of the target behavior and its function. Psychology staff claim that KF's aggression occurs because KF often wants something or wants to get away from something. However, in drawing their conclusions, the staff have not answered important questions such as: what does KF actually want, who does she want it from, and when does she want it. KF's psychology examiner admitted to Dr. Manikam that he does not see "the value of using standardized measures." The failure to use standardized measures to help answer questions about the functions of KF's behavior, before implementing treatment programs, is a substantial departure from generally accepted professional standards. US Ex. 572; Manikam Tr. 3150:6-3152:9.

21) **GDG/GDB (GDB was transcribed as GDG)**

GDB's case illustrates the problems with CHDC's long delays in the development and implementation of behavior programs, unreliable assessments and data collection, static treatment plans, disorganized treatment process, and psychology staff's lack of familiarity with applied behavioral analysis. Matson 1086:1-1089:20, 1142:2-1143:24; Manikam Tr. 3104:15-3109:11; *see also* Reddig Tr. 2041:7-2051:7; US Exs. 563-1, 701-4 through 701-6 (other examples of repetitive plan language).

More specifically, GB's case shows problems with assessments of psychopathology. GB has diagnoses of "anxiety disorder" and "personality change" that make little sense for someone with his level of developmental disability or with the types of behaviors supposedly of concern to the staff. GB has one of the unusual diagnoses that are common at CHDC – "personality change due to unspecified encephalopathy." Matson Tr. 1086:1-1090:21, 1142:2-1143:24; Manikam Tr. 3104:15-3109:11.

GDB has a safety plan with both restraints and other restrictive measures. His plan has a program date of February 25, 2010, and a May 31, 2010 implementation date. Not only does it take CHDC a long time to implement behavioral plans, in many cases such as GB's, staff make no significant changes to plan elements from one year to the next. Matson Tr. 1086:1-1090:21.

GB's behavioral interventions are inadequate. Matson Tr. 1086:1-1090:21, 1142:2-1143:24; Manikam Tr. 3104:15-3109:11. The interventions are too vague to be useful (e.g. "redirected to an appropriate activity."). Matson Tr. 1091:5-23. Different components of GB's treatment program give different functions for his behaviors. Matson Tr. 1086:1-1090:21, 1142:2-1143:24; Manikam Tr. 3104:15-3109:11. For instance, in one document, the intervention calls for withholding GB's radio. In another, the intervention is to offer the radio. One document indicates that the function of his aggression is to seek attention. Another makes no reference to attention seeking at all, instead attributing his behavior to a desire for tangible items – like his radio. Problematically, one of the behavioral interventions listed in his various treatment programs actually calls for giving him tangible items, like his radio, when he exhibits his challenging behaviors. At a very basic level, this example shows how staff do not understand how to utilize "reinforcement" and related behavioral concepts. When shown the different

documents, Dr. Reddig conceded that the interventions may actually reinforce his behavior, given the assessed function of those behaviors. Reddig Tr. 2043:3-2045:14-18.

The data kept for GB is disorganized. Different records document different levels of aggressive behavior for this individual. GB also has no formal communication program. Staff set GB's drug taper criteria in a manner that makes it unlikely he can ever meet them. Staff use a papoose board as part of GB's program and his behaviors or restraint use appears to have increased over time while his treatment plan remained static. Matson Tr. 1086:1-1090:21, 1142:2-1143:24; Manikam Tr. 3104:15-3109:11; Reddig Tr. 2050:9-51:2-7; *see also* US Exs. 701-1, 701-2.

22) **BH**

BH's case illustrates the problems with CHDC's unreliable assessments and data collection, disorganized treatment process, and psychology staff's lack of familiarity with applied behavioral analysis. Matson 1160:16-1164:7; Manikam Tr. 3113:16-3116:25.

BH has numerous diagnoses, many more than would normally be expected. Matson 1160:6-1164:7. Yet, staff used no specific scales or methods of measurement to determine the diagnoses. As with many other cases at CHDC, diagnoses do not match up with targeted behaviors, his functional assessment, and treatment. For instance, BH supposedly has both anxiety disorder and bipolar disorder. It is very unusual for anyone who is profoundly mentally retarded to also have a manic disorder (bipolar). At the same time, the behaviors being tracked do not match up with expected symptoms of the diagnoses.

BH also supposedly has "pica behavior," and a behavior involving "eating feces and smearing feces." Matson Tr. 1162:24-1164:3. His behavioral program does not adequately address his pica behavior, but targets the supposed anxiety or escape triggers for the behavior

without an adequate functional assessment. Matson Tr. 1162:24-1164:3. Moreover, different documents offer different antecedents for BH's behavior, making it difficult to ensure that there are specific treatments tailored to the alleged functions of the behavior. Matson 1160:6-1164:7; Manikam Tr. 3113:16-3116:25.

He also has a safety plan that utilizes a one piece jump suit restraint to prevent him from smearing and eating feces. Manikam Tr. 3113:16-3116:25. The way the safety plan is written suggests that the jump suit is being at used for staff convenience (it calls for using the jump suit so they do not have to redirect him as often) rather than for appropriate, programmatic treatment purposes.

Defendants extensively cited to BH's records to try to demonstrate quality care. Warren Tr. 4797:9-4801:13. Yet, they could offer little or no evidence that staff evaluated behavioral triggers, such as BH's recent surgery and possible pain. Nor did staff utilize adequate behavioral interventions before resorting to the drastic step of using electroconvulsive shock therapy to diminish BH's poorly defined target behaviors.

23) **KH**

KH is 12 years old. Manikam Tr. 3111:7-10. KH's case again illustrates the problems with CHDC's unreliable assessments and data collection, disorganized treatment process, and staff's lack of familiarity with principles of applied behavioral analysis. Manikam Tr. 3111:7-3113:18. KH has been diagnosed as moderately mentally retarded even though her records suggest she's actually higher functioning. KH's behavioral program involves use of a "point system." Under this system, there is little relationship between the number of points she earns towards obtaining privileges and her behaviors. This system is yet another example of the staff's poor understanding of applied behavioral approaches to managing behavior. Moreover, when

KH fails to earn points, most of the responses are in the form of punishment procedures. Given the results of her assessments, such an approach is not likely to be very effective. US Ex. 573; Manikam Tr. 3111:7-3113:18.

24) **JM**

JM was a 21 year old resident. US Ex. JW-2. JM's case illustrates the harm that results to CHDC residents from long delays in the development and implementation of behavior programs and staff's lack of familiarity with principles of applied behavioral analysis. US Exs. 68-2, 68-3, JW-2; Weaver Tr. 340:8-362:2. JM's behavioral issues were very serious. Staff noted in April 2009 that JM needed a safety plan, but they still had not implemented one by the time the treatment team met in August 2009. In the meanwhile, staff placed him in mechanical restraints at least 36 times during the period from April through September 2009. In developing JM's treatment program, his program coordinator carefully documented progress on relatively meaningless goals, such as JM's ability to identify differences between quarters and dimes. Yet, she barely addressed much more important issues such as his behaviors and restraints. US Exs. 68-2, 68-3, JW-2; Weaver Tr. 340:8-362:2

25) **BLR**

BLR's case is a particularly telling example of how psychology staff fail to facilitate placement of residents in the most integrated setting appropriate to the individual's needs. Matson Tr. 1173:23-1175:21; US Ex. 641. According to the assessment completed by CHDC staff, BLR supposedly exhibits behaviors when transitioning from home visits to the facility. In response to this assessment, the staff have decided that the appropriate intervention is to condition BLR to accept living in a facility, while delaying home visits. This is not an appropriate behavioral approach for dealing with someone who does not react well to transitions

between settings. Instead of teaching the resident or his family how to handle transitions by increasing the resident's experience with transitions, the approach used by CHDC basically reinforces acceptance of isolation and institutionalization. US Ex. 641; Matson Tr. 1173:23-1175:21.

26) **WR, Jr.**

WR is 19 years old. Reddig Tr. 2051:22-25. WR's case illustrates the problems with CHDC's unreliable assessments and data collection, disorganized treatment process, staff's lack of familiarity with principles of applied behavioral analysis, and psychology staff's lack of understanding regarding their role in facilitating placement of residents in the most integrated setting appropriate to the individual's needs. Reddig Tr. 2051:8-2063:2; US Ex. 576.

WR is a young man with a history of severe abuse. WR has a papoose board, restraint chair, and personal holds as part of his behavioral program. Additionally, WR is also on the "levels of reinforcement system" ("point system"). Even with these very restrictive measures, Dr. Reddig admits that WR is not considered an outlier in terms of restraint use. Reddig Tr. 2051:8-2063:2.

Staff told WR's guardian that he was making "great progress," so they were going to drop him from enhanced supervision and the point system. Reddig Tr. 2054:23-2055:4. Yet, WR was actually exhibiting numerous problematic behaviors, including running away repeatedly and having to be placed on suicide precautions, which were the same types of behaviors that supposedly required that he be institutionalized instead of being housed in a community placement. His records also show that there were significant discrepancies between what the psychiatrist and the psychologist were reporting in terms of his level of behaviors, and correspondingly different responses. For instance, from February to July 2008, WR had no

incidents of aggression; yet his medications were being increased supposedly because of an increase in aggression. Reddig Tr. 2060:5-2062:11.

27) **JS**

JS's case illustrates the problems with CHDC's unreliable assessments and diagnoses. Matson Tr. 1175:22-1177:22; US Ex. 640. Like many other residents at CHDC, JS has several psychiatric diagnoses. The more diagnoses a person possesses, the more likely the diagnoses are unreliable. In this case, JS supposedly has obsessive-compulsive disorder (OCD), schizophrenia, and dementia. Yet, dementia and schizophrenia are typically incompatible with the OCD diagnosis. JS's case illustrates how diagnoses, such as OCD, are being used by CHDC staff to cover a variety of behaviors when staff fail to properly differentiate between different behaviors and their true causes. Matson Tr. 1175:22-1177:22.

28) **NS**

NS is 12 years old. Manikam Tr. 3119:8-16. NS's case illustrates the harm posed to CHDC residents from CHDC’s unreliable assessments and data collection, disorganized treatment process, and staff's lack of familiarity with principles of applied behavioral analysis. Manikam Tr. 3119:8-16; US Ex. 578. For NS, psychology staff are actually collecting more data than they do for other residents, but even in this case, the data is not being incorporated into appropriate treatment plans. NS exhibited over 30 episodes of aggression per month during the period covered by witness testimony. Staff developed a program that did not actually address many of the factors that they themselves claimed triggered her aggression. They also developed behavioral objectives that required that NS learn to ask to take a break, apparently because such “communication training” would help with her behaviors. Yet, the objectives used an arbitrary

schedule that could actually *delay* communication skills acquisition. Manikam Tr. 3119:8-3122:8.

29) **MW**

MW's case illustrates the problems with CHDC's unreliable assessments and data collection, disorganized treatment process, and staff's lack of familiarity with principles of applied behavioral analysis. Warren Tr. 4778:18-4787:15. MW's diagnoses and target behaviors are confused and poorly defined. MW's records list many different target behaviors, and treatment changes occur over time without clear indication of which behaviors are actually the focus of the treatment changes. For instance, some CHDC treatment records indicate that his behaviors have improved. Yet, around the same time, Dr. Callahan, CHDC's psychiatrist, indicated in his psychiatry notes that MW's condition has been getting worse. *See generally* Warren Tr. 4778:18-4787:15.