No. 21-60772

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff - Appellee

VERSUS

THE STATE OF MISSISSIPPI,
Defendant – Appellant

Appeal from the United States District Court
for the Southern District of Mississippi
Civil Action No. 3:16-CV-622-CWR-FKB

BRIEF OF DEFENDANT-APPELLANT

LYNN FITCH
Attorney General
DOUGLAS T. MIRACLE
Assistant Attorney General
STATE OF MISSISSIPPI
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 220
Jackson, MS 39205-0220
Telephone: (601) 359-3680
Email: doug.miracle@ago.ms.gov

James W. Shelson
Nash E. Gilmore
Phelps Dunbar LLP
4270 I-55 North
Jackson, MS 39211-6391
Telephone: (601) 352-2300
Email: jim.shelson@phelps.com
Email: nash.gilmore@phelps.com

Counsel for Defendant-Appellant

CERTIFICATE OF INTERESTED PERSONS

Under this Court's Rule 28.2.1, governmental parties need not furnish a certificate of interested persons.

/s/ James W. Shelson
James W. Shelson
Counsel for Defendant-Appellant

STATEMENT REGARDING ORAL ARGUMENT

The district court relied on a groundbreaking theory of liability to rule that the State of Mississippi violated Title II of the Americans with Disabilities Act and entered a sweeping remedial order that subjects the State's entire mental-health system to perpetual federal oversight. The issues presented on appeal are novel, complex, and important. Oral argument would aid the Court's resolution of the case.

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INTRODUCTION

This Court should reverse the district court's extraordinary judgment ruling that the State of Mississippi violated Title II of the Americans with Disabilities Act (ADA) and should reject that court's sweeping remedial order establishing the district judge as the perpetual overseer of the State's mental-health system.

Title II bars a State from discriminating against a person with disabilities by unjustifiably institutionalizing that person. Mississippi complies with Title II. It has a comprehensive mental-health system in which the treating physicians work with their patients to decide where and how they should be treated, based on the needs of the patients and the resources available to them. The parties to this case and the district court agree that Mississippi's mental-health system complies with Title II "on paper." ROA.3896; *see* ROA.3913. Yet the district court concluded that, "in practice," the State has violated Title II based on the view that the mental-health system's operation places all persons with serious mental illness "at risk" of being institutionalized. ROA.3896-97. That view in turn rested on determinations made by non-treating physicians about the placement of a sample of patients and its conclusion that the State was not acting "fast enough" on a systemwide basis to provide "a minimum bundle of community-based services." ROA.3896-97, ROA.3953-54. The district court then rejected Mississippi's defense that, to provide the services the United States claimed to be necessary, the State would have to "fundamentally alter" its mental-health system. Finally, two years after its liability opinion was issued, the district court imposed a sweeping remedial order that lacks objective criteria and allows a court-appointed monitor to dictate how Mississippi

should run its mental-health system—even though the State had altered its system to meet the criteria advocated by the United States and adopted by the district court at trial.

The district court's liability and remedial orders rest on serious, reversible errors.

First, the district court erred in concluding that Mississippi violated Title II. While recognizing that, "[o]n paper, Mississippi has a mental health system with an array of appropriate community-based services," the district court endorsed the United States' claim that the system, "in practice," puts all citizens with serious mental illness "at risk of institutionalization" across the board because the State was not moving "fast enough" to implement and extend those community-based services. ROA.3896-97, ROA.3903. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court held that unjustified institutionalization is discrimination on the basis of disability, and it established a three-factor test to determine when *individuals* are unjustifiably institutionalized in violation of Title II. *Id.* at 587, 597. The three factors do not fit the United States' systemwide claim challenging Mississippi's entire mental-health system based on the speculative risk of institutionalization to each citizen with serious mental illness. Nor did the United States or the district court point to any specific policy or procedure that created a risk to individuals of unjustified institutionalization. Rather, the district court ruled that, because a handful of non-treating physicians determined that certain individual patients—who are not parties to this case—were unjustifiably hospitalized, the entire state mental-health system's operation violates Title II. No court has ever held that an entire mental-health system

violates Title II or *Olmstead* on that flawed theory. And this Court should reject the district court's attempt to stretch Title II and *Olmstead* to fit the United States' systemwide claim.

Second, the district court independently erred in rejecting the State's fundamental-alteration defense to liability. A "public entity" is not obligated to "make reasonable modifications in [its] policies, practices, or procedures" as "necessary to avoid discrimination on the basis of disability" when "the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7). Mississippi established at trial that the United States' proposed "reasonable modifications" would fundamentally alter its services and programs. The facts have borne this out. Mississippi has taken the steps the United States and the district court recognized as necessary at trial to further increase the availability of community-based services, which came at substantial cost to the State. This defense alone requires reversal of the district court's judgment.

Finally, the district court erred in issuing a sweeping remedial order and in appointing a monitor. By the time those orders were issued, Mississippi had voluntarily implemented all of the changes to its community-based services to the level the United States and the district court agreed at trial were necessary. Despite rendering the need for any additional order moot, the district court moved the target for compliance by requiring *additional* steps beyond the previously stated standard. The remedial order also creates serious federalism problems and lacks any objective criteria for its termination. The district court's order appointing a monitor exacerbates

the remedial order's defects by holding the State's mental-health system hostage without any clear path to the remedial order's termination. For any of these reasons, even if the district court's liability holding is affirmed, the remedial order and the order appointing a monitor should be vacated.

STATEMENT OF JURISDICTION

This is an action brought by the United States against the State of Mississippi under Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134. The district court had subject-matter jurisdiction under 28 U.S.C. §§ 1331 and 1345. The district court entered final judgment on September 7, 2021. ROA.4321. Mississippi filed a notice of appeal on October 6, 2021. ROA.4341. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

I. In *Olmstead*, 527 U.S. 581, the Supreme Court held that Title II of the ADA prohibits the unjustified institutional isolation of persons with disabilities. No court appears to have considered a Title II claim invoking *Olmstead* except to consider either individual cases or class actions of improper institutionalization, or the increased risk of institutionalization to specific persons arising from a challenged state policy. Did the district court here err in imposing Title II liability by expanding *Olmstead's* three-factor test for individualized relief to apply to the mental-health system of an entire State where: (i) the district court recognized that Mississippi has "an array of appropriate community-based services"; (ii) in line with *Olmstead*, the State trusts its treating physicians to decide on a case-by-case basis where to place

their patients; (iii) no specific state law or policy is being challenged; and (iv) no individualized or class-action relief was sought?

II. Under Title II, a State is required to make "reasonable modifications" to avoid discrimination, but not where such modifications would fundamentally alter the State's services and programs. 28 C.F.R. § 35.130(b)(7). Did the district court err in rejecting Mississippi's fundamental-alteration defense where Mississippi showed at trial that the United States' proposed "reasonable modifications" would fundamentally alter its services and programs by requiring the State to nearly double the amount of certain services at extraordinary cost to the State?

III. Even if the liability determination were correct, did the district court abuse its discretion in issuing a remedial order and an associated order appointing a monitor to evaluate Mississippi's compliance where: (i) by the time those orders were issued, Mississippi was already in compliance with the standard of services the United States had proposed and the district court adopted; (ii) the remedial order creates serious federalism problems; (iii) the remedial order lacks any objective criteria for its termination or an end date; and (iv) the remedial and monitor orders together hold the State's mental-health system hostage by permitting the monitor and the United States extraordinary access to persons, facilities, and documents within the state system without a clear path to satisfying the remedial order.

STATEMENT OF THE CASE

Legal Background. In 1990, Congress passed the ADA to "provide a clear and comprehensive national mandate for the elimination of discrimination against

individuals with disabilities." 42 U.S.C. § 12101(b)(1). Title II of the ADA applies to "public entities," which includes state governments. 28 U.S.C. §§ 12131(A), (B). In the provision underlying this case, Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

The ADA instructed the Attorney General to issue regulations implementing Title II. Two regulations are central here. First, under the integration-mandate regulation, "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The integration mandate does not say that persons allegedly at serious risk of institutionalization have a viable claim under Title II, or that a viable systemwide claim exists based on such a theory. Second, under the reasonable-modifications regulation, "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." *Id.* § 35.130(b)(7).

About a decade after the ADA was enacted, the Supreme Court "confront[ed] the question whether [Title II's] proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions." *Olmstead*, 527 U.S. at 587. The Supreme Court answered this question with a "qualified yes." *Id*. Specifically, the Court held that "[u]njustified isolation ...

is properly regarded as discrimination based on disability," *id*. at 597, but ruled that an individual's placement in the community is required only when three conditions are satisfied: "when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id*. at 587. *Olmstead* arose from the claims of two individuals, and the Court's test focuses on individualized determinations, recognizing that such determinations must account for the State's ability to manage "the allocation of available resources" given its "responsibility ... for the care and treatment of a large and diverse population of persons with mental disabilities." *Id.* at 604 (plurality opinion). *Olmstead* did not consider when a State's mental-health system as a whole would be insufficient under Title II, nor did it announce standards for making such a determination. Further, *Olmstead* contemplated that actual institutionalization that was unjustified would violate Title II. It did not address whether placing individuals at serious risk of unjustified institutionalization would violate Title II, or what could constitute such a risk.

Factual Background. Mississippi's public mental-health system is a multi-faceted system that involves the delivery of mental-health services by various state entities. ROA.3903, ROA.3659, ROA.8455. The Mississippi Department of Mental Health is the state agency generally responsible for providing mental-health services. ROA.3659. The Department operates four State Hospitals: Mississippi State Hospital at Whitfield, East Mississippi State Hospital in Meridian, South Mississippi State

Hospital in Purvis, and North Mississippi State Hospital in Tupelo. ROA.6707-08. Each State Hospital has a "catchment" area. ROA.6709. The catchment areas contain the counties that each State Hospital serves. ROA.6709. Adults with serious mental illness are admitted to the State Hospitals through a statutorily prescribed involuntary civil-commitment process in state chancery courts. ROA.3937, ROA.6930. If a chancery judge issues a commitment order, a State Hospital must admit the person who was committed. ROA.6930.

Community Mental Health Centers (CMHCs) are the providers of community-based services in Mississippi. ROA.6260-61. The CMHCs are organized by Region. The Regions consist of a catchment area of one or more counties served by the CMHCs. ROA.6259.

The mental-health continuum of care is an array of services across different service environments where an individual is able to receive services and may move step-wise or progress from one level of the continuum to the next, hopefully in the direction from more restrictive to less restrictive. ROA.5553. The continuum ranges from the lowest intensity of services (traditional outpatient services) to the highest intensity of services (State Hospitals). ROA.5325-26.

In Mississippi, community-based services are provided through a continuum of care that includes the core services at issue in this case, which are delivered by the CMHCs. ROA.3665-69, ROA.4122-25, ROA.6004. Mobile Crisis Services are designed to stabilize a person in crisis at the location where the person is experiencing the crisis. ROA.3666. Crisis Stabilization Units provide mental-health services to persons experiencing psychiatric crises and are designed to prevent longer-term

hospitalization. ROA.3666. Intensive Community Services are delivered in multiple ways, including through Programs of Assertive Community Treatment (PACT) and Intensive Community Outreach and Recovery Teams (ICORTs). ROA.4123. PACT is a mobile service delivered by an interdisciplinary team of mental-health professionals to persons with the most severe and persistent mental illness. ROA.3665. PACT is the most intensive and expensive community-based service. ROA.5274, ROA.6136-37. As of the trial's fact cut-off date, December 31, 2018, Mississippi had no ICORTs, but after trial and before the entry of the remedial order Mississippi developed and implemented ICORTs to deliver Intensive Community Services to less densely populated or rural areas that are hard to serve with PACT teams. ROA.4123. Mississippi has provided funding for sixteen ICORTs. ROA.4123. By the time the remedial order was entered—nearly three years after the trial fact cut-off date of December 31, 2018—Mississippi had also added five Crisis Stabilization Units, two PACT teams, Peer Support programs, Supported Employment programs, and housing vouchers for individuals with serious mental illness. ROA.4123-25.

Mississippi provides mental-health services in other ways, too. For example, Peer Support is provided by Certified Peer Support Specialists—persons who have received mental-health services and have received training and state certification. ROA.3668. Supported Employment assists persons with mental illness in obtaining competitive employment. ROA.3667. Supported Housing provides housing vouchers to help persons with mental illness obtain housing in the community. ROA.3667-68.

In urging that the State's system overly favors institutionalization, the United States retained six experts to survey 154 individuals out of a potential 3,951 (or 3.89%) who had been hospitalized in a Mississippi State Hospital one time or more between October 2015 and October 2017. ROA.3931-32. The experts reviewed the individuals' medical records and sought to interview them. ROA.3933. The United States supplied four questions the experts were instructed to answer regarding each individual. ROA.4787-88. The experts concluded that 85% of the 154 individuals surveyed were at serious risk of institutionalization. ROA.3933-34.

Procedural Background. In 2016, the United States sued Mississippi for allegedly violating Title II of the ADA. The United States' single-count complaint alleged that "[t]he State violates the ADA by administering the State's mental health service system in a manner that denies qualified adults with mental illness the benefits of the State's mental health services ... in the most integrated setting appropriate to their needs and by failing to reasonably modify the State's mental health services system to avoid discrimination against adults with mental health disabilities." ROA.75-76. The United States did not bring suit on behalf of any individual person or class of persons who had allegedly been unjustifiably institutionalized. It did not challenge any specific state policy or procedure as violating Title II. Rather, the United States argued that the operation of Mississippi's mental-health system writ large placed every citizen of the State with serious mental illness at risk of improper institutionalization. ROA.3903.

On September 3, 2019, following a four-week bench trial, the district court issued a liability opinion holding that Mississippi's entire mental-health system was

in violation of Title II of the ADA. ROA.3895-3955. The district court recognized that this Court has not reviewed a similar systemwide case. ROA.3905. In holding the State liable on a systemwide basis here, the district court embraced the United States' theory that "all Mississippians with [serious mental illness] are denied the most integrated setting in which to receive services, and are at serious risk of institutionalization." ROA.3903. Under that theory, persons living in the community—and who thus are not institutionalized—have a viable Title II claim under *Olmstead* if they are at serious risk of institutionalization. ROA.3904-05. Unlike other courts that have adopted this theory, the district court here ruled that it applied even where there is no specific policy or procedure that allegedly is placing persons at risk. ROA.3907.

In ruling that Mississippi's mental-health system placed all its citizens with serious mental illness at risk of unjustified institutionalization, the district court looked to *Olmstead's* three-factor test for determining when individuals are unjustifiably institutionalized. ROA.3946-48. As noted above, the first factor is triggered "when the State's treatment professionals have determined that [the individual's] community placement is appropriate." 527 U.S. at 587. The second factor hinges on whether "the transfer from institutional care to a less restrictive setting is not opposed by the affected individual." *Id.* The third factor asks whether "placement" of the individual in a community setting "can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* The district court concluded that the first factor was satisfied because the United States' experts "determined that the individuals they

interviewed would be appropriate for community-based services," a determination based on the opinions of non-treating experts. ROA.3946. The court concluded that the second factor was satisfied because the United States' experts "found that everyone they interviewed, except for one individual, was not opposed to treatment in the community." ROA.3947. The court concluded that the third factor was satisfied because the United States' expert, Melodie Peet, "testified that the State already has the framework for providing these services, and can more fully utilize and expand that framework to make the services truly accessible." ROA.3947. Recognizing that there was nothing fundamentally wrong with how Mississippi's mental-health system was structured, the district court framed the "main question" as whether Mississippi had "moved fast enough" to implement changes and ensure that all "adults with [serious mental illness]" are fully integrated into "the communities in which they live and work." ROA.3896-97. The district court ruled that the State had not moved fast enough. ROA.3897.

Next, the district court rejected Mississippi's arguments that the remedies sought by the United States would require fundamental alterations to the State's mental-health system. ROA.3948-51. The court rejected Mississippi's fundamental-alteration defense because, it held, "community-based services and hospitalization cost the system approximately the same amount of money" and "budgetary constraints alone are insufficient to establish a fundamental alteration defense." ROA.3950.

After issuing the liability opinion, the district court appointed a Special Master, Dr. Michael Hogan, to conduct settlement negotiations with the parties on a remedy.

ROA.4024-27. Meanwhile, the State voluntarily implemented the changes the court and the United States at trial had agreed were necessary by increasing its PACT teams, Crisis Stabilization Units, Mobile Crisis Response Teams, Supported Employment, Peer Support, and CHOICE housing vouchers.[1] ROA.4122-25. While Mississippi was making these changes, the parties continued to negotiate for about a year, but did not reach a settlement. ROA.7317-18. The district court then ordered the parties and the Special Master to each submit a proposed remedial plan, ROA.4070, and each did so by mid-2021, ROA.4100-31 (State); ROA.4145-60 (United States); ROA.4236-58 (Special Master).

In July 2021, after proposed remedial plans were submitted, the district court held a hearing. ROA.7283-7479. On July 14, 2021, the court adopted Dr. Hogan's proposed remedial plan "in full," and ordered the parties to each submit two names of a possible monitor and proposals for the monitor's role. ROA.4277-88.

On September 7, 2021—about two years after it issued its liability opinion—the district court entered a remedial order (ROA.4310-17), an order appointing Dr. Hogan as monitor (ROA.4318-20), and a final judgment (ROA.4321).

Paragraph 1 of the remedial order requires Mississippi to "develop and implement effective measures to prevent unnecessary institutionalization in State Hospitals." ROA.4310. Paragraph 2 provides that the CMHCs shall be the entity in its Region responsible for preventing unnecessary hospitalizations by implementing

[1] Mississippi provides Supported Housing through a program called CHOICE. ROA.3667, ROA.9843. CHOICE provides rental assistance to make housing affordable for individuals with serious mental illness. ROA.8455.

four very broadly stated measures. ROA.4310. Paragraphs 3-11 dictate the mix and quantity of community-based services that Mississippi must have. ROA.4310-13.

Paragraph 12 requires Mississippi to annually allocate $200,000 for a medication-assistance fund. ROA.4313. Paragraph 13 requires Mississippi to implement a host of measures intended to divert individuals from State Hospitals. ROA.4134. Paragraph 14 requires Mississippi to contact the individuals in the United States' 154-person survey, screen them for eligibility for community-based services, and offer them services for which they are appropriate and eligible. ROA.4314. Paragraph 15 requires Mississippi to implement eight enumerated measures into its discharge planning process at State Hospitals. ROA.4314. Paragraph 16 imposes additional discharge-planning requirements for individuals who have been previously admitted to a State Hospital in the prior one-year period. ROA.4314. Paragraph 17 requires the CMHCs to meet with individuals before they are discharged from State Hospitals. ROA.4314. Paragraph 18 requires Mississippi to annually provide technical-assistance training to each county's chancery courts. ROA.4315. Paragraph 19 requires Mississippi to "provide technical assistance to providers including competency-based training, consultation, and coaching." ROA.4315.

Paragraphs 20 and 21 comprehensively require Mississippi, on a monthly basis, to collect, review, and analyze person-level and aggregate data capturing eight enumerated categories of data. ROA.4315. Paragraph 22 requires Mississippi to annually "analyze by CMHC the current compliance status of all CMHC Core Services programs with the DMH Operational Standards, and for those Core Services

where fidelity is monitored, on the current fidelity score/status." ROA.4135. Paragraph 23 requires Mississippi to "design, with the participation of the DOJ and the Monitor, a Clinical Review Process to assess the adequacy of services received by a small sample (*e.g.*, 100-200) of individuals receiving Core Services and/or State Hospital care." ROA.4315. Paragraph 24 requires Mississippi to "post on agency websites and provide on an annual basis to the DOJ and Monitor that data described in Paragraphs 19-21" of the order. ROA.4315.

Paragraph 25 requires Mississippi to develop an Implementation Plan for complying with the order. ROA.4315-16. Paragraph 26 requires Mississippi to "provide the initial Implementation Plan to the Monitor and the DOJ for comment within 120 days of the issuance of this Order and … submit the final proposed Implementation Plan to the Monitor with[in] 180 days." ROA.4316. Paragraph 27 addresses termination of the order and provides: "This Order shall terminate when the State has attained substantial compliance with each paragraph of this Order and maintained that compliance for one year as determined by this Court." ROA.4316. Paragraph 28 provides that the district court "will appoint a Monitor to act as an agent of the Court to assess the State's compliance with this Order." ROA.4316.

Mississippi moved for a partial stay of the remedial order pending appeal, ROA.4322-25, the United States did not oppose the partial stay, ROA.4343-44, and the district court stayed paragraphs 10.b, 11.b, 23, 25, and 26 of the order pending this appeal, ROA.4357.

After the entry of the district court's orders, this appeal followed. ROA.4341.

SUMMARY OF ARGUMENT

I. The district court erred in holding that Mississippi is in violation of Title II of the ADA. Title II prohibits discrimination against individuals with disabilities in the services, programs, or activities of public entities. 42 U.S.C. § 12132. To comply with Title II, States are required to ensure that their services and programs place individuals in "the most integrated setting appropriate to [their] needs." 28 C.F.R. § 35.130(d). Mississippi's system complies with these standards. It provides a range of services to citizens with mental disabilities, and it trusts treating physicians to determine the best placement for individuals on a case-by-case basis by considering the patient's individual needs and the resources available within the State.

The district court did not dispute that Mississippi's system complies with Title II "on paper." ROA.3896. It did not point to any specific state policy (and the United States did not challenge any policy) that violates Title II. Rather, the district court held that Mississippi violates Title II based on an expanded reading of the Supreme Court's opinion in *Olmstead*, 527 U.S. 581. *Olmstead* created a test for determining when *individual* patients are unjustifiably institutionalized and thus not placed in the most integrated setting. Here, the district court ruled that—"in practice"—Mississippi was not moving "fast enough" to expand its community-based services, which resulted in all of its citizens with serious mental illness being "at risk" of institutionalization. ROA.3896-97, ROA.3905-07.

The district court erred in holding that Mississippi is in violation of Title II. First, the district court transformed the *Olmstead* test, which focuses on individuals and their needs, to apply to an entire state system. This expansion has no basis in

Title II or *Olmstead*. Second, even if *Olmstead* recognized such broad liability, the district court's at-risk-of-institutionalization theory finds no grounding in Title II or *Olmstead*. Even courts that have recognized that theory have applied it where a specific policy creates the "risk." No appellate court has ever applied it to a State for its failure to move "fast enough" to expand its available services. Third, and independently, even if the "at risk" theory were valid, the district court's factual findings that Mississippi violated that standard were grossly erroneous.

II. The district court erred in rejecting Mississippi's defense that the changes requested by the United States and adopted by the district court required fundamental alterations to the State's mental-health system. The proposed changes required the State to nearly double the amount of its Crisis Stabilization Units and its PACT teams. These changes required enormous expenditures by the State. By any metric, those sweeping state-wide and systemwide directives are "fundamental alterations."

III. The remedial order is, by itself, an abuse of discretion requiring vacatur. No remedial order was appropriate because when the order was entered—two years after the district court held the State liable—the State was in compliance with the standard advocated by the United States and previously embraced by the district court. The remedial order also raises fundamental federalism problems by permitting the district court and the United States to micromanage a State's mental-health system. The order also lacks any meaningful criteria as to how it may be satisfied. The district court exacerbated these problems by issuing an order appointing a monitor, who has authority (along with the United States) to further interfere with the State's ability to operate its mental-health system.

STANDARD OF REVIEW

"The standard of review for a bench trial is well established: findings of fact are reviewed for clear error and legal issues are reviewed *de novo*." *One Beacon Ins. Co. v. Crowley Marine Servs., Inc.*, 648 F.3d 258, 262 (5th Cir. 2011). When a district court's factual findings are "essentially based on an incorrect legal principle, [the] Rule 52(a) clearly erroneous [standard] does not apply and [this Court] disregard[s] any such possible findings." *Delta S.S. Lines, Inc. v. Avondale Shipyards, Inc.*, 747 F.2d 995, 1000 (5th Cir. 1984), *reh'g denied*, 753 F.2d 378 (5th Cir. 1985).

ARGUMENT

I. The District Court Committed Reversible Error In Ruling That Mississippi Violated Title II Of The ADA.

Title II prohibits discrimination against individuals with disabilities in the services, programs, or activities of public entities. 42 U.S.C. § 12132. The integration mandate requires public entities to administer their "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). To comply with the integration mandate, the reasonable-modifications regulation requires public entities to make reasonable modifications in their policies, practices, or procedures when necessary to avoid discrimination, unless the modifications would fundamentally alter the nature of the service, program, or activity. 28 C.F.R § 35.130(b)(7). The opinions of treating physicians are required under *Olmstead*. *See Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003) (recognizing that the first factor of *Olmstead* requires a determination by "treatment professionals ... that community

placement is appropriate"); *see also Olmstead*, 527 U.S. at 587 (Kennedy, J., concurring in judgment) ("The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.").

Mississippi's mental-health system complies with these standards. To start, it bears emphasizing at the outset that the United States claimed and the district court ruled that Mississippi's mental-health system discriminates in violation of Title II and the integration mandate on a systemwide basis, despite the fact that it pointed to no systemwide defect. The court did not base its conclusion on any unlawful policy that places individuals outside "the most integrated setting appropriate," nor was any such policy challenged. Indeed, the court found that "on paper," Mississippi's system was sufficient. ROA.3896. Nor was this case brought on behalf of a single individual who had allegedly been placed outside "the most integrated setting appropriate," much less on behalf of a class of such individuals.

The United States was right not to bring—and the district court was right not to endorse—such claims. The State satisfies Title II on a systemwide basis. It provides a range of services to its citizens with mental disabilities, and it trusts its treating physicians to determine—in conjunction with their patients—the best placement on an individual basis, balancing the specific needs of the individual with the resources available within the state. As a long-term Department of Mental Health employee explained at trial, Mississippi had moved its mental-health system from institutional-based care to community-based care, and Mississippi has "a very good solid system that provides care and services for people." ROA.6358. Dr. Hogan

confirmed that "the state is approaching an equilibrium with respect to its balance of community services and state hospital [care]." ROA.7349. The district court said that "the people that care for Mississippians suffering from [serious mental illness] should be recognized for their efforts to expand community-based care. The State has made some strides." ROA.3952. The State continues to take steps to reasonably modify and improve its system—even when such improvements go beyond what the law requires and fundamentally alter the system. Such is the case here: Mississippi implemented *all* of the changes the United States and the district court agreed at trial were necessary even though such changes came at great cost and fundamentally altered the mental-health system. During the remedial hearing in July 2021, Dr. Hogan recognized "that there have been significant improvements over time in Mississippi and that there is some quality that exists in those services." ROA.7319.

The district court generally agreed that, "on paper," Mississippi's system complies with Title II. *See* ROA.3896 ("On paper, Mississippi has a mental health system with an array of appropriate community-based services."). Yet it ruled that the State violated Title II because, "in practice," its system "excludes adults with [serious mental illness] from full integration into the communities in which they live and work, in violation of the [ADA]." ROA.3896-97. It based this decision not on a specific policy, but rather on a novel extension of the Supreme Court's test in *Olmstead* for determining when an *individual* is unjustifiably institutionalized. Based on this extension, and based on the opinions of non-treating experts about the placement of a sample of individuals, the court held that Mississippi's system places *all* citizens "at risk" of institutionalization. But the requirement that public entities

provide "services, programs, and activities in the most integrated setting appropriate" does not say that persons allegedly at serious risk of institutionalization have a viable claim under Title II, let alone that the United States has a viable *systemwide* claim based on such a theory. In relying on the "at risk" theory, the district court overlooked that *Olmstead* ruled that unjustified institutionalization is discrimination under Title II, but that it did not likewise find that placing individuals "at risk" of institutionalization is discrimination under Title II. 527 U.S. at 596. And the district court pointed to no policy that created such a risk (nor was any challenged). Rather, the court ruled that the risk arose because Mississippi was not moving "fast enough" to place individuals in community-based settings. The district court in effect applied the logic of specific "as-applied" challenges on a systemwide basis, something typically reserved for facial challenges to a specific policy.

No court has ever similarly ruled that a State's entire mental-health system violates Title II based on such reasoning. The district court was wrong to do so. Its ruling condemning the State's mental-health system rests on two serious errors.

First, the district court improperly extended *Olmstead*, which contemplates individual determinations, not systemwide claims.

In *Olmstead*, two individuals—L.C. and E.W.—were institutionalized in a Georgia state hospital. 527 U.S. at 593. L.C.'s and E.W.'s treating professionals determined that community-based programs were medically appropriate for them, and that they should be discharged to such programs. *Id*. Yet L.C. and E.W. remained institutionalized. *Id*. They filed suit, alleging that Georgia's failure to place them in a community-based program, once their treating professionals determined that such

placement was appropriate, violated Title II. *Id*. at 594. On these facts, the Supreme Court "confront[ed] the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than institutions." *Id*. at 587. In answering with a "qualified yes," the Court held that such placement was required "when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual who is institutionalized, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* Each of these three factors focuses on an individual. A State's treatment professionals must determine that community placement is appropriate *for that institutionalized individual*. The transfer from institutional care to the community must not be opposed "by the affected individual." *Id.* And the placement *of the institutionalized individual* must be able to be reasonably accommodated, taking into account the needs of *others*. *Olmstead* did not confront the materially different question whether a State's mental-health system as a whole is sufficient to comply with Title II. The district court erred in trying to make *Olmstead*'s test fit the United States' systemwide claim.

To start, *Olmstead* holds that placing persons with serious mental illness in community settings rather than institutions may be warranted when the State's treatment professionals determine that community placement is appropriate. *Id.* at 587. This reliance on treating physicians makes sense: those professionals understand the needs of their patients best. It is of sufficient importance that *Olmstead* made it

the first factor of its three-factor test for determining when individuals are appropriate for transfer from an institution to the community—*i.e.*, "when the *State's treatment professionals have determined* that community placement is appropriate." *Id*. at 587 (emphasis added). The district court here, however, relied on non-treating experts hired by the United States. These experts based their determinations not on actual treatment of any individual person, but on a survey of 154 Mississippians (out of 3,951) who had been hospitalized at least once between 2015 and 2017 and a review of those 154 individuals' medical records, ROA.3932-33, ROA.4958. In doing so, the district court made assumptions about *all* Mississippians with serious mental illness based on a limited sample (something not contemplated by *Olmstead*'s individual-focused test), but sidestepped the requirement that the determinations be made by the State's treating physicians. ROA.3932-34. But *Olmstead* was clear that "the State generally may rely on the reasonable assessments *of its own professionals* in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program." 527 U.S. at 602 (emphasis added). In its own amicus brief in *Olmstead*, the United States recognized that the Attorney General interprets the integration mandate regulation "to require a State to provide services to persons with disabilities in a community setting, rather than in an institution, *when a State's treatment professionals have determined*, in the exercise of reasoned professional judgment, that community placement of the individual is appropriate." ROA.3533 (emphasis added). The liability opinion identifies no instance where a treating physician at a Mississippi State Hospital concluded that a person was appropriate for discharge but was not discharged. Instead, while

recognizing that *Olmstead* requires a determination by a "treatment physician," the court erroneously concluded that the opinion of any such physician will suffice, even if that physician is not employed by the State. ROA.3902. But the court failed to abide by even this standard, as it not only discounted the opinions of the State's treating physicians, but accepted without explanation the opinions of non-treatment experts whose conclusions were based primarily on a survey of four questions and a review of medical records. From these errors, it made sweeping conclusions about all Mississippi citizens with serious mental illness.

Next, *Olmstead* asks whether the transfer from institutional care to a less-restrictive setting is not opposed by the affected individual. *Olmstead*, 527 U.S. at 587. The district court erred once again in trying to make this prong fit the survey conducted by the United States' experts. The district court once again reached sweeping conclusions about all Mississippi citizens with serious mental illness based on a survey of only a few. And the selected participants for the survey essentially dictated its conclusion: of those surveyed, 81% were already living in the community when asked whether they would oppose community-based treatment. ROA.3933-34. This selection turns the question on its head; if the individuals surveyed believed that they would be better served in an institution, they would (under the United States and district court's own reasoning) have been presumptively placed in a hospital.

In short, *Olmstead* established a test that, by its terms, contemplates actual individualized determinations made by treating physicians regarding whether institutionalized individuals are appropriate for treatment in the community—not conclusions based on sample sizes and outside experts regarding individuals already

living in the community. That test for individualized relief simply does not fit the United States' claim for systemwide relief in this case.

Second, on top of improperly making a systemwide determination based on a test for individualized determinations, the district court erroneously embraced the United States' theory that Title II imposes liability in the absence of actual institutionalization. In particular, the district court relied on a theory that Mississippi's mental-health system placed its citizens with serious mental illness "at serious risk of institutionalization." ROA.3905-07. This theory—which bases liability not on actual discrimination but on the alleged potential of discrimination—has not been recognized by this Court or the Supreme Court. And even courts that have recognized it apply it only where a specific state policy creates such a risk, not based on assessments of individual patients.

The Tenth Circuit's decision in *Fisher*, 335 F.3d 1175, is representative of courts applying the "at risk" theory. *Fisher* concluded that nothing in the integration mandate limits protection to persons who are currently institutionalized. *Id*. at 1181. *See also Steimel v. Wernert*, 823 F.3d 902, 912 (7th Cir. 2016) (same); *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013) (same). *Fisher* quoted the integration mandate, asserting that it "simply states that public entities are to provide 'services, programs, and activities in the most integrated setting appropriate' for a qualified person with disabilities." *Fisher*, 335 F.3d at 1181. But the integration mandate's text says nothing about "at serious risk of institutionalization." That public entities must provide "services, programs, and activities in the most integrated setting appropriate" does not say that persons allegedly at serious risk of institutionalization have a viable

claim under Title II, let alone that the United States has a viable systemwide claim based on such a theory.

Fisher nevertheless reasoned that the protections of the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." 335 F.3d at 1181; *see also Steimel*, 823 F.3d at 912 (same). That rationale has no application here. There are no individual plaintiffs in this case, nor is it a class action. There is no allegation that Mississippi is trying to enforce a discriminatory law or policy. The allegation here is that, if Mississippi's mental-health system expanded "fast enough" to provide additional community-based services, then fewer people would be "at risk" of being institutionalized. ROA.3897, ROA.3904-07. Nothing in *Fisher* or its progeny suggests that a mental-health system that allegedly has an insufficient quantity of community-based services—or that, as the district court put it, is not moving fast enough to expand those services, ROA.3897—violates Title II by putting persons at serious risk of institutionalization.

Fisher also said that, "while it is true that the plaintiffs in *Olmstead* were institutionalized at the time they brought their claim, nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA's integration requirements." 335 F.3d at 1181. But *Olmstead*'s individualized test forecloses that view. That the plaintiffs in *Olmstead* were institutionalized when they brought their claim is critical to its holding and its application. By focusing on an individual's circumstances and the determinations

made by his or her treating physician, the Court made clear it was not focusing on how a State's decisions writ large could affect *other* persons.

This reading of *Olmstead* is bolstered by the Court's reference to the Attorney General's interpretation of Title II, which focused on actual institutionalization. *Olmstead* observed that in carrying out the integration mandate, "the Attorney General concluded that unjustified *placement or retention* of persons in institutions ... constitutes a form of discrimination based on disability prohibited by Title II." 527 U.S. at 596 (emphasis added).

In sum, nowhere does *Olmstead* extend Title II to those "at risk" of institutionalization.

Even if *Olmstead* could be stretched to encompass individuals "at risk" of institutionalization, each court to have adopted that theory based its liability determination on a challenge to a specific policy—such as limiting prescription medications or reducing the amount of in-home personal care services—that allegedly placed one or more individuals, or a class of them, at serious risk of institutionalization. None of the cases used the approach the district court took here: tallying alleged flawed applications of mental-health case to condemn the State's system writ large. ROA.3896 ("In practice, however, the mental health system is hospital-centered and has major gaps in its community care.").

- *Fisher* involved three plaintiffs who alleged Oklahoma's decision capping prescription medications for participants in the waiver program at five per month would force them out of their communities and into nursing homes. 335 F.3d at 1177-78. The Tenth Circuit held that individuals "who, by reason of a

change in state policy, stand imperiled with segregation, may not bring a challenge to that state policy under the ADA's integration regulation without first submitting to institutionalization." *Id*. at 1182.

- *M.R. v. Dreyfus*, 697 F.3d 706 (9th Cir. 2012), involved a class action of plaintiffs in the State of Washington. *Id*. at 720. The State adopted a regulation that reduced the amount of in-home personal care services under Washington's Medicaid plan. *Id*. The plaintiffs alleged that the reduction in hours violated the ADA because it substantially increased the risk that they would have to be institutionalized to receive adequate care. *Id*.
- *Pashby*, 709 F.3d 307, involved thirteen plaintiffs who lost access to in-home personal care services when North Carolina imposed stricter eligibility requirements for such services. *Id*. at 313.
- *Steimel*, 823 F.3d 902, involved plaintiffs in Indiana who were developmentally disabled. *Id*. at 906. The case involved Indiana's three Medicaid waiver programs: A&D waiver, CIH waiver, and FS waiver. *Id*. The A&D waiver had no cap on services, but the FS waiver had a $16,545 annual cap. *Id*. Indiana enacted a policy change that moved the plaintiffs from the A&D waiver to the FS waiver. *Id*. The plaintiffs alleged that the policy change placed them at serious risk of institutionalization. *Id*. at 913.
- *Davis v. Shah*, 821 F.3d 231 (2d Cir. 2016), involved a class of individuals in New York. *Id*. at 237. Until 2011, New York's Medicaid program provided orthopedic footwear and compression stockings to all beneficiaries for whom such services were medically necessary. *Id*. at 240. New York was facing a

> fiscal crisis, so it amended its Medicaid plan to limit coverage for both orthopedic footwear and compression stockings. *Id*. The amendments caused the plaintiffs to lose funding for their orthopedic footwear and compression stockings. *Id*. at 242. The plaintiffs alleged that the amendments placed them at serious risk of institutionalization. *Id*. at 261.

Olmstead spoke only to individualized determinations. Even if extending its logic to cases that create the "risk" of institutionalization based on a facial challenge to a policy had some logic, no court has ever extended *Olmstead* both to apply across an entire State's system *and* where there is no state specific state policy that allegedly created such a risk. Such a theory creates liability even where—as here—the State's policies are sound, and where there is no evidence that a treating physician's opinion about proper placement has been overruled. This logic turns *Olmstead*—which recognizes the importance of such individualized determinations by a treating physician—on its head.

Finally, and independent of the points set out above, even were the "at risk" theory viable, the factual showing at trial failed to demonstrate that persons with serious mental illness in Mississippi are at such a risk on a systemwide basis. To start, although the United States' experts found that 85% of the individuals they surveyed were at serious risk of hospitalization (ROA.4961), these experts did not have a common understanding of what "at risk" meant. Dr. Robert Drake testified that patients are "at risk" if they do not have a medication regimen that works for them and that they can follow, they do not have stable housing, they are abusing alcohol or drugs, and they do not have a regular meaningful activity in the

community. ROA.4791. Dr. Beverly Bell-Shambley found the individuals she surveyed were "at risk" "[b]ecause absent them receiving appropriate community-based services, I felt like they were at risk for reoccurrence or worsening of symptoms and ultimately a return to the hospital." ROA.5498. Katherine Burson determined "at risk" by considering whether "if they had had services provided that had been shown to mitigate the risk of hospitalization, were those services sufficient to help mitigate that risk." ROA.5750. It is not clear which—if any—of these experts' opinions of "at risk" was accepted and relied upon by the district court.

Further, the expert opinions and findings themselves suffered from significant flaws. Dr. Bell-Shambley found that Person 4 was at serious risk of institutionalization, although he was living independently in his apartment, was receiving social security disability benefits, and was managing his own funds.[2] ROA.5561-62. Dr. Bell-Shambley found that Person 23 was at serious risk of institutionalization, although he was living independently in his home, was not having any problems with his medication, and was doing well living independently in the community. ROA.5562. Dr. Judith Baldwin found Person 105 was at serious risk of institutionalization, although she was living in a two-bedroom apartment, the apartment was neat and clean, Person 105 was cooking her own meal when Dr. Baldwin arrived for the interview, she was oriented in all spheres, she had created a stable life for herself in the community, and she had not been hospitalized for nearly two years. ROA.5716-18.

[2] To protect their privacy, the individuals in the survey were each assigned a number, and they are referred to in the trial record by that number—*e.g.*, Person 60.

The "at risk" assessments of the United States' experts are also confounded by objective data. Dr. Drake conducted a literature review regarding how effective community-based services are at reducing hospitalizations. ROA.8037-41. The data, which considered PACT programs nationwide, show that they are only 41% effective at reducing hospitalizations, meaning it is ineffective 59% of the time. ROA.8037. As Dr. Drake explained, "if there were 100 at risk people who would otherwise be hospitalized, 41 of them would not be rehospitalized during that interval [one year to 18-months] if they received [PACT]." ROA.4815-16. Under that logic, if every individual in the survey who the United States' experts thought should receive PACT services had received those services, at least 59% of them were going to be re-hospitalized. But the data from the literature review did not constrain the United States' experts from claiming that community-based services are 100% effective at reducing hospitalizations in Mississippi. Rather, those experts found that 100% of the individuals surveyed would have avoided or spent less time in the hospital if reasonable community-based services had been available. ROA.4788, ROA.4960. The experts (and the district court) failed to distinguish, however, the data above showing community-based services fall well short of 100% effectiveness. ROA.3933-34.

In short, there is no clear or articulated standard provided by the United States' experts or the district court for when an individual is "at serious risk of institutionalization." Nor can any such standard be found in the text of Title II, its implementing regulations, *Olmstead* or other case law. For all of these reasons, this

Court should reject the "at risk" theory here. The State is entitled to judgment in its favor.

II. The District Court Committed Reversible Error When It Rejected Mississippi's Fundamental-Alteration Defense.

Independent of the legal errors discussed above, Mississippi is entitled to judgment in its favor based on the "fundamental alteration" defense. The modifications to Mississippi's mental-health system the United States proposed at trial fundamentally alter that system—most critically, as to the number of PACT teams, and Crisis Stabilization Units needed. "Sensibly construed, the fundamental alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." *Olmstead*, 527 U.S. at 604 (plurality opinion).

The district court ruled that "the United States' experts showed that providing community-based services can be reasonably accommodated within Mississippi's existing mental health system," but that ruling is unsound. ROA.3947. The court's ruling was based on the opinion of one of the United States' experts, Melodie Peet, who testified that Mississippi should have specific community-based services—PACT, Crisis Stabilization Units, Mobile Crisis Teams, Supported Employment, and Peer Support—in each Region. ROA.6066, ROA.6070-71, ROA.6072-73, ROA.6115-16, ROA.6134. Setting aside that Ms. Peet, herself, acknowledged that not "every effective mental health system" has all of these services, ROA.6004,

implementing these changes required significant, fundamental alterations to the system of care in Mississippi. Specifically:

- The United States proposed that Mississippi have a PACT team in every Region of the state. ROA.6066. As of the trial evidentiary cut-off date of December 31, 2018, Mississippi had 8 PACT teams, so it would have to add 6 new PACT teams to have PACT in every Region. ROA.4123. The Mississippi Department of Mental Health provides a $600,000 annual grant to each of its PACT teams. ROA.3666. Thus, it would cost $3,600,000 annually to fund six new PACT teams.
- The United States said that Mississippi would need to provide a Crisis Stabilization Unit in each Region. ROA.6070. As of the trial fact cut-off date of December 31, 2018, Mississippi had Crisis Stabilization Units in 8 of its 14 Regions, meaning that it needed to add 6 Crisis Stabilization Units to have one in each Region. ROA.3667, ROA.4123. At the time of trial, Crisis Stabilization Units in Mississippi are 4-, 8-, or 16-bed units. ROA.6292-93. The Mississippi Department of Mental Health provides $800,000 annual funding to 4- and 8-bed units, and $1,400,000 annual funding for 16-bed units. ROA.6293. Thus, it would cost at least $4,800,000 annually to add 6 new Crisis Stabilization Units.

As this evidence shows, the United States' proposed modifications required Mississippi to fundamentally alter its mental-health system by nearly doubling the amount of Crisis Stabilization Units and PACT teams. Making these changes alone would also cost the State $8,400,000.

That the State took such steps to voluntarily implement the changes previously deemed necessary, as discussed below, does not change the fact that such changes required fundamentally altering the State's system, or that the district court was wrong to reject the defense at trial prior to the changes occurring. The decision of how best to set up a mental-health system, including how and where to make changes to that system, are fundamentally the province of the State, not a district court. As the Supreme Court recognized in *Horne v. Flores*, 557 U.S. 433, 448 (2009), "a federal court decree has the effect of dictating state or local budget priorities. States and local governments have limited funds. When a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs."

Olmstead recognized that, "[i]n evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides to others with mental disabilities, and the State's obligation to mete out those services equitably." 527 U.S. at 597. Under this standard, the United States' proposed modifications at trial fundamentally alter Mississippi's mental-health system, as do the requirements of the remedial order. The State had to drastically expand the services—on a state-wide basis—it was offering to comply with what the court and the United States said was needed. By any sound measure, such a sweeping, systemwide rehauling is a fundamental alteration.

The district court rejected Mississippi's fundamental-alteration defense in its liability opinion by focusing on cost alone, ruling that community-based services and hospitalization cost about the same and that budgetary constraints alone do not establish a fundamental alteration. ROA.3950. As an initial matter, the changes required far more than an enormous monetary expenditure. Nearly doubling the amount of Crisis Stabilization Units and PACT teams are significant alterations.

Even considering cost alone, the district court was wrong. *Olmstead* makes clear that "courts may not merely compare the cost of institutionalization against the cost of community-based health services because such a comparison would not account for the state's financial obligation to continue to operate partially full institutions with fixed overhead costs." *Frederick L. v. Dep't of Pub. Welfare of Pa.*, 364 F.3d 487, 493 (3rd Cir. 2004) (citations omitted). But this is the type of comparison the court made when concluding that community-based services and hospitalization cost about the same. ROA.3950. Such a comparison is "precisely the sort of reductive cost comparisons proscribed by the *Olmstead* plurality …, as well as by Justice Kennedy," *Frederick L.*, 364 F.3d at 497, so the district court committed legal error in rejecting Mississippi's fundamental-alteration defense on this basis.

The district court also erred in ruling that "[t]he weight of authority indicates that 'budgetary constraints alone are insufficient to establish a fundamental alteration defense.'" ROA.3950. *Olmstead* noted that "[t]he Court of Appeals construed [the reasonable modifications] regulation to permit a cost-based defense 'only in the most limited of circumstances.'" 527 U.S. at 603 (plurality opinion). The Supreme Court disagreed, ruling that "construction of the reasonable-modifications regulation ...

unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks." *Id*. And in its own consideration of the defense, the only factor the *Olmstead* Court mentioned was cost. *Id*. at 603-04 (plurality opinion).

In short, the United States sought extraordinary changes to a mental-health system that, according to the district court, had "an array of appropriate community-based services." ROA.3896. It required the State to nearly double the amount of Crisis Stabilization Units and PACT teams, changes that would require extraordinary expenditures by the State. Yet the district court ruled that these changes did not amount to a fundamental alteration of Mississippi's mental-health system. And, as discussed in Part III below, the court's failure to appreciate the proper scope of what constitutes a "fundamental alteration" led it to impose even more onerous requirements after Mississippi had complied with the requirements identified above. The district court was wrong, and this Court should reverse.

III. The District Court Abused Its Discretion In Issuing The Remedial Order And Order Appointing A Monitor—Requiring Vacatur Of Both Orders.

If this Court upholds the district court's liability determination, it should nevertheless hold that the district court abused its discretion in issuing the remedial order and the associated order appointing a monitor to evaluate Mississippi's compliance with the remedial order. By the time those orders were issued, Mississippi had voluntarily taken upon itself to meet the standard the United States and the district court agreed was required by Title II. Although any purported deficiencies that were previously identified had been rectified, the district court

ordered new and additional relief—relief that the State never had an opportunity to contest at trial because it was never identified as necessary. The remedial order also creates serious federalism problems and lacks any objective criteria for when it can be terminated. In addition, the order appointing a monitor exacerbates the remedial order's defects, holding the State's medical system hostage without any clear understanding of when or how the remedial order can be satisfied. For these reasons, this Court should vacate both orders.

A. When the remedial order was entered Mississippi already satisfied the standard of services proposed by the United States and adopted by the district court.

No remedial order was necessary given the current state of Mississippi's mental-health system. In its liability opinion the district court itself was "hesitant to enter an Order too broad in scope or too lacking in a practical assessment of the daily needs of the system. In addition, it is possible that further changes might have been made to the system in the months since the factual cutoff." ROA.3954. As that court contemplated, the State made further changes to its system in the years since the factual cutoff—changes that brought the State into compliance with the standard set forth by the United States at trial and adopted by the district court. "If a durable remedy has been implemented, continued enforcement of [an] order is not only unnecessary, but improper." *Horne*, 557 U.S. at 450.

The district court nonetheless issued a sweeping remedial order. The court concluded that "the United States' experts showed that providing community-based services can be reasonably accommodated within Mississippi's existing mental-

health system." ROA.3947. To support this conclusion, the district court once again cited only Melodie Peet. The court noted that "Ms. Peet testified that the State already has the framework for providing these services, and can more fully utilize and expand that framework to make the services truly accessible." ROA.3947. Ms. Peet testified that Mississippi should have core community-based services in each Region as follows: One PACT Team and/or Intensive Case Management in each Region; One Crisis Stabilization Unit in each Region; One Mobile Crisis Response Team in each Region; Supported Employment in each Region; and Peer Support in each Region. ROA.6066, ROA.6070-71, ROA.6072-73, ROA.6115-16, ROA.6134. Ms. Peet also testified that Mississippi should have "sufficient" CHOICE housing vouchers. ROA.6035-37.

Mississippi was in compliance with the standard of services that Ms. Peet recommended prior to the entry of the remedial order—and remains in compliance today—so no remedial order was appropriate.

Mobile Crisis Response Teams. Ms. Peet recommended that Mississippi have a Mobile Crisis Team in each Region. ROA.6134. As of the trial's fact cut-off date, Mississippi had fourteen Mobile Crisis Response Teams and the Teams were in all of its Regions.

Crisis Stabilization Units. Ms. Peet recommended that Mississippi have a Crisis Stabilization Unit in each Region. ROA.6070. As of the trial's fact cut-off date, Mississippi had Crisis Stabilization Units in eight Regions, but it now has Crisis Stabilization Units in all Regions. ROA.4123.

Intensive Community Services—PACT/ICORT/ICSS. Ms. Peet recommended that Mississippi have a PACT Team and/or Intensive Case Management in in each Region. ROA.6115-16. Mississippi provides Intensive Community Services through three programs: PACT, ICORT, and Intensive Community Support Specialists (ICSS). ROA.4123. Mississippi now exceeds the level of services proposed by Ms. Peet for Intensive Community Services by providing funding for Intensive Community Services not simply in every Region, but in every *county* through PACT, ICORT, and/or ICSS. This increase in coverage was accomplished through the following:

- As of the trial's fact cut-off date, Mississippi had eight PACT teams. It now has ten PACT teams. ROA.4123. Mississippi's PACT teams are located in the Regions shown on ROA.4126-4127.
- As of the trial's fact cut-off date, Mississippi had no ICORTs. Since then, Mississippi developed and implemented ICORT to deliver Intensive Community Services to less densely populated or rural areas that are difficult to serve with PACT teams. ROA.4123. In FY19, Mississippi piloted ICORT in Region 2. ROA.4123. Mississippi now has provided funding for sixteen ICORTs. ROA.4123.
- Mississippi now has funding for 35 ICSS as shown at ROA.4126-27.

Peer Support Services. Ms. Peet recommended that Mississippi have Peer Support Services in each Region. ROA.6072-73. Mississippi provides Peer Support Services in every Region by providing funding for Peer Support Services as a standalone service available at the primary CMHC office in each Region. ROA.4124. As of the

trial's fact cut-off date, Mississippi had a Peer Bridger program at North Mississippi State Hospital in Tupelo. The Peer Bridger program helps patients make the transition to the community when they are discharged from a State Hospital. In the current fiscal year, Mississippi will have a Peer Bridger Program at all of its State Hospitals. ROA.4124. By having Peer Support Services available in every Region, plus imminently having the Peer Bridger program at all State Hospitals, Mississippi exceeds the level of services for Peer Support Services proposed by Ms. Peet.

Supported Employment. Ms. Peet recommended that Mississippi have Supported Employment in each Region. ROA.6072. Mississippi now provides all Regions with a grant to provide Supported Employment through either Individual Placement and Support or an Employment Specialist that partners with Vocational Rehabilitation. ROA.4124. Mississippi meets the standard proposed by Ms. Peet for Supported Employment.

Supported Housing. In the current fiscal year, Mississippi will provide an additional $150,000 to the two CHOICE housing providers to conduct assessments of people discharged from the State Hospitals and Crisis Stabilization Units. ROA.4125. And in the current fiscal year, the Mississippi Legislature appropriated an additional $400,000 for CHOICE housing vouchers. ROA.4125.

The tables at ROA.4128-31 show the expansion of the core community-based services in Mississippi since 2013. A green check mark indicates that Mississippi has core community-based services in the applicable Region. These tables show that Mississippi now has those services in the quantities Ms. Peet said it should have.

Because Mississippi complies with the standard proposed by the United States' expert and adopted by the district court, there is no basis to conclude that Mississippi is violating Title II or to issue a remedial order. Despite such compliance, in the remedial order the district court moved the target and required *additional* modifications to Mississippi's system. For example, although Peer Support Services were discussed at trial, the requirement in paragraph 10.b of the remedial order that Mississippi implement a plan to provide Peer Support Services at satellite CMHC offices (ROA.4313) was not mentioned at trial, and Ms. Peet did not suggest any such requirement. And paragraphs 12-28 of the remedial order do not discuss core community-based services (ROA.4313-16), which was the extent of what Ms. Peet and the district court originally said was required by Title II. For this reason alone, the remedial order exceeds what is required to comply with Title II according to the testimony of the United States' own expert. *Stukenberg v. Abbott*, 907 F.3d 237, 272 (5th Cir. 2018) (district court may not order relief beyond what is minimally required to comport with statute).

Because the district court ordered relief beyond what it previously held was required to comply with Title II, this Court should vacate the remedial order.

B. The remedial order defies fundamental principles of federalism.

The remedial order also flouts the limitations of federalism.

In "a system of federal courts representing the Nation, subsisting side by side with 50 state judicial, legislative, and executive branches, appropriate consideration must be given to principles of federalism in determining the availability and scope

of equitable relief." *Rizzo v. Goode*, 423 U.S. 362, 379 (1976); *E.T. v. Paxton*, 19 F.4th 760, 770 (5th Cir. 2021) (same). The remedial order creates serious federalism problems because it authorizes sweeping relief that invades the inner workings of state government.

At the time of trial, Dr. Marc Lewis had worked for the Mississippi Department of Mental Health for nearly twenty-four years and was the Director of the Bureau of Certification and Quality Outcomes. ROA.6346. Dr. Lewis testified that "some of the [CMHCs] ... have identified that they don't need a PACT team in Byhalia, Mississippi or some other rural area because there's not a need. And even if they had a PACT team, finding a psychiatrist to staff it or a psych nurse practitioner to staff that PACT team ... it couldn't be achievable in our state, and we'd be back in this court arguing why a model that works in another state can't work in Mississippi." ROA.6382-83. Dr. Lewis's testimony shows why "one of the most important considerations governing the exercise of equitable power is a proper respect for the integrity and function of local government institutions." *Missouri v. Jenkins*, 495 U.S. 33, 51 (1990).

The remedial order's federally imposed oversight of a State's entire system defies principles of federalism. The Supreme Court has condemned far lesser intrusions. In *Rizzo*, for example, the plaintiffs sued the Mayor of Philadelphia, Pennsylvania, its Police Commissioner, and other city officials, alleging a "pervasive pattern of illegal and unconstitutional mistreatment by police officers." 423 U.S. 362, 366 (1976). The district court entered an order requiring the Police Commissioner to put in force a directive governing the manner by which citizens' complaints against

police officers had to be handled by the department. *Id*. at 366. The Supreme Court held that the district court's order "represents an unwarranted intrusion by the federal judiciary into the discretionary authority committed to them by state and local law to perform their official functions." *Id*. The Court concluded that "the principles of federalism which play such an important part in governing the relationship between federal courts and state governments ... have applicability where injunctive relief is sought ... against those in charge of an executive branch agency of state or local government. ... When it injected itself by injunctive decree into the interdisciplinary affairs of this state agency, the District Court departed from these precepts." *Id*. at 380; *cf. Valentine v. Collier*, 956 F.3d 797, 803 (5th Cir. 2020) (holding that district court irreparably injured State by issuing an injunction extensively micromanaging state prison system).

The district court here failed to show the respect for state government institutions that our federalist system demands. This failure is especially problematic in institutional-reform cases like this one. "[I]nstitutional reform injunctions often raise sensitive federalism concerns. Such litigation commonly involves areas of core state responsibility." *Horne*, 557 U.S. at 448; *see also id.* (federalism concerns are heightened where "a federal court decree has the effect of dictating state or local budget priorities" and "[w]hen a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs").

All paragraphs of the remedial order carry costs that will require legislative appropriation, as the monitor recognized when he stated that "there are a lot of costs to the State in carrying this [remedial order] out." ROA.7358. Ms. Peet, too,

recognized that "[r]esources are finite in every state. It will always be a challenge to find additional resources to devote to the funding of community programs." ROA.6145. That is so "because state governments operate within a fixed set of resources and the legislature and governor are always looking at competing needs when they're making allocation decisions." ROA.6145. Ms. Peet noted that analyzing the proper mix of institutional care versus community care is a balancing act because state mental-health administrators must constantly assess where they are spending finite dollars. ROA.6147. These points underscore that the sweeping remedial order wrongly upends state functions and authority.

Indeed, the remedial order inserts the district court (and the monitor and DOJ) into the day-to-day management of Mississippi's mental-health system. The remedial order dictates requirements for the management of CMHCs, the mix and quantity of core community-based services that Mississippi must have, a fund for medication access, diversion from State Hospitals, outreach efforts to the individuals in the survey conducted by the United States' experts, discharge planning at the State Hospitals, technical assistance, data collection and review, the creation of a Clinical Review Process, and the development of an Implementation Plan. ROA.4310-17.

Just as the Constitution does not "charge[ ] federal judges ... with running state prisons," *Valentine v. Collier*, 978 F.3d 154, 165 (5th Cir. 2020) (citation omitted), neither the Constitution nor Title II charges federal judges with running state mental-health systems. "Principles of federalism and separation of powers dictate that exclusive responsibility for administering state prisons resides with the State and its officials." *Id*. at 166 (citation omitted). Those same principles dictate that the

responsibility for administering state mental-health systems should reside with the State and its officials. The district court exceeded the appropriate limits of its remedial power because the remedial order "lays claim to" the State's "resources, commanding how it must allocate its time, funding, and facilities. In doing so, it necessarily interferes with" the State's "flexibility to address the facts on the ground, which, as has been repeatedly recognized in this litigation, are ever-changing." *Id*. at 165.

There are "federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts." *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring in judgment). Here, those federalism costs are constitutionally intolerable. Vacatur is warranted on this ground too.

C. The remedial order lacks objective criteria for its termination.

The remedial order is not narrowly tailored because it requires Mississippi to attain "substantial compliance" with each paragraph of the order, without providing an indication of how that compliance is to be measured. ROA.4316. Long after the trial had concluded, the United States submitted a proposed remedial order that did not include any proposed performance measures. ROA.4148-60, ROA.7395-96. To this date, no showing has been made regarding how, if at all, any particular performance measure will indicate compliance with Title II. For example, Dr. Hogan testified that Mississippi's community-based services should be measured according to fidelity. ROA.7333. "Fidelity" is a performance measure—the concept is that the

higher the score on a fidelity scale, the better the service is being performed. ROA.7387. Fidelity scales exist for PACT and Supported Employment, but they do not exist for any other community-based services or for any of the paragraphs of the remedial order that do not directly address those services. ROA.7385, ROA.7407. Except for PACT and Supported Employment, fidelity scales for the community-based services must be made up going forward. Worse still, fidelity scales are not designed to equate to compliance with the ADA (ROA.7408), so Mississippi, subject to the oversight of the district court, the monitor, and the United States, must invent a series of fidelity scales to measure compliance with each paragraph of the remedial order that, at the end of day, do not even relate to compliance with the ADA. The remedial order, therefore, "encompass[es] more conduct than was requested [and exceeds] the legal basis of the lawsuit." *Paxton*, 19 F.4th at 769.

Because the remedial order does not clearly define what is substantial compliance, the State does not know when—or if—it is complying with the Order. "The federal court must exercise its equitable powers to ensure that when the objects of the decree have been attained, responsibility for discharging the State's obligations is returned promptly to the State and its officials." *Frew v. Hawkins*, 540 U.S. 431, 442 (2004). Because the remedial order has no objective criteria for termination, there is no objective way to know when "the objects of the decree have been attained." *Id.*

D. The order appointing a monitor exacerbates the remedial order's defects.

Finally, the district court erred in appointing a monitor to evaluate Mississippi's compliance with the remedial order. ROA.4318-20.

The order appointing the monitor substantially adopts the United States' proposal for the role of the monitor. ROA.4289-91. The order provides that "the Monitor, including any staff retained by the Monitor, and the United States shall have full access to persons, employees, residences, facilities, buildings, programs, services, documents, records (including medical and other records in unredacted form), and any other materials necessary to assess the State's compliance with the Remedial Order." ROA.4319-20. This order exacerbates the overreach of the remedial order for at least three reasons.

First, the order effectively makes the United States a second monitor. At this stage of the litigation, the United States is not conducting an investigation or discovery. The Order appointing Dr. Hogan has no rationale or explanation for why the United States has the same "full access" that the monitor has. Fed. R. Civ. P. 53 allows courts to appoint monitors, but it does not allow a party—here, the United States—to act as a parallel monitor or to monitor the actual monitor. Even if this Court rules that the appointment of a monitor is within the scope of what is "minimally required" to comply with Title II, allowing the United States to act as a parallel monitor or to monitor Dr. Hogan exceeds what is "minimally required" to monitor compliance.

Second, the order's grant of "full access" to the Monitor and the United States "as necessary to assess the State's compliance with the Remedial Order" is improperly boundless. Paragraph 20a.-g. of the remedial order enumerates the data that Mississippi is required to collect and review. ROA.4315. Although the remedial order specifies the data Mississippi must collect, the order appointing a monitor allows the monitor and the United States to make Mississippi collect whatever data they deem "necessary to assess the State's compliance with the Remedial Order." ROA.4319-20. Access to data should be limited to the data that Mississippi is required to collect under paragraph 20. Otherwise, there effectively are no limits regarding the data the monitor and United States can seek from Mississippi.

Finally, the extraordinary authority of the monitor and the United States exacerbates the prior concerns that the remedial order has no objective criteria for its termination. As a result, Mississippi is under court order to indefinitely comply with all of their requests.

* * *

For all of these reasons, the district court abused its discretion in issuing the remedial order and the order appointing Dr. Hogan as monitor, and those orders should be vacated.

CONCLUSION

This Court should reverse the judgment below and order judgment for Mississippi. At the least, the Court should vacate the district court's remedial order.

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Respectfully submitted,

LYNN FITCH
Attorney General
Douglas T. Miracle
Assistant Attorney General
STATE OF MISSISSIPPI
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 220
Jackson, Mississippi 39205-0220
Telephone: (601) 359-3680
E-mail: doug.miracle@ago.ms.gov

/s/ James W. Shelson
James W. Shelson
Nash E. Gilmore
Phelps Dunbar LLP
4270 I-55 North
Jackson, MS 39211
Telephone: (601) 352-2300
Email: jim.shelson@phelps.com
nash.gilmore@phelps.com

Counsel for Defendant-Appellant

CERTIFICATE OF SERVICE

I, James W. Shelson, hereby certify that the foregoing brief has been filed with the Clerk of Court using the Court's electronic filing system, which sent notification of such filing to all counsel of record.

Dated: January 10, 2022.

/s/ James W. Shelson
James W. Shelson
Counsel for Defendant-Appellant

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS AND TYPE STYLE REQUIREMENTS

This brief complies with the word limitations of Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32, it contains 12,561 words. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in proportionally-spaced typeface, including serifs, using Microsoft Word Version 2016, in Times New Roman 14-point font, except for footnotes, which have been prepared the same way except in 12-point font.

Dated: January 10, 2022.

/s/ James W. Shelson
James W. Shelson
Counsel for Defendant-Appellant