IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

LARS KNIPP by his next friend, Deborah Stone; JAMES KIM, by his next friend, Grace Kim; SUSANNAH TROGDON, by her next friend, Samuel Trogdon; AMBI HEARD; SHAUN MITCHELL; and ROBERT CHAFFIN by his next friends, Tom Chaffin and Lena Margareta Larsson Chaffin,	)	
Plaintiffs,	)	CIVIL ACTION 1:10-CV-2850-TCB
v.	)	
GEORGE ERVIN "SONNY" PERDUE III, in his official capacity as Governor, State of Georgia, CLYDE L. REESE, III in his official capacity as Commissioner, Georgia Department of Community Health; DR. FRANK E. SHELP, in his official capacity as Commissioner, Georgia Department of Behavioral Health and Developmental Disabilities.	)	
Defendants.	)	

STATEMENT OF INTEREST OF THE UNITED STATES

The United States respectfully submits this Statement of Interest, pursuant to 28 U.S.C. § 517,[1] because this litigation implicates the proper interpretation and

[1] 28 U.S.C. § 517 permits the Attorney General to send any officer of the Department of Justice "to any State or district in the United States to attend to the

application of Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et. seq.* ("ADA"), and in particular, its integration mandate. *See Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has authority to enforce Title II, 42 U.S.C. § 12133, and to issue regulations implementing the statute, 42 U.S.C. § 12134. The United States thus has a strong interest in the resolution of this matter and urges the Court to grant the plaintiffs' motion for preliminary injunction.

Additionally, the United States advises the Court of its right to intervene in this action pursuant to 28 U.S.C. § 2403 to address a question of constitutionality of an Act of Congress affecting the public interest.[2] In their response filed on October 4, 2010, defendants assert that they are immune under the Eleventh Amendment from private suits under Title II of the Americans with Disabilities Act ("ADA"), claiming that "some courts have held that Congress failed to abrogate Eleventh Amendment immunity for states under Title II of the [ADA] and further that immunity may still exist for states in suits brought under Title II where there is no underlying constitutional violation alleged." *See* Defendants' Response to Motion for Preliminary Injunction ("Defs.' Resp."), ECF No. 23 at 8-9.

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interests of the United States in a suit pending in a court of the United States."

[2] 28 U.S.C. 2403 provides: "In any action, suit or proceeding in a court of the United States to which the United States … is not a party, wherein the constitutionality of an Act of Congress affecting the public interest is drawn in question, the court shall … permit the United States to intervene for … argument on the question of constitutionality."

The United States typically defends the constitutionality of Title II of the ADA in all contexts and anticipates that it will file a notice of intervention to address the constitutionality question raised by the defendants. In accordance with Department of Justice procedures, however, authorization from the Office of the Solicitor General is required in advance of filing a notice of intervention under 28 U.S.C. § 2403. Given that defendants' constitutionality challenge was raised only two days ago, the United States respectfully requests the Court's permission to submit a brief addressing defendants' constitutional challenge on or before October 28, 2010.[3]

INTRODUCTION

This lawsuit alleges that defendants, the Governor of the State of Georgia and the Commissioners of the Department of Community Health and the Department of Behavioral Health and Developmental Disabilities (collectively, "Georgia" or "the State"), are placing the plaintiffs at serious risk of hospitalization by terminating the Medicaid-funded services plaintiffs need to remain in their current settings without offering any alternative support services.

[3] We also advise this Court that a two-week hearing has been scheduled to begin on November 8, 2010 with respect to the United States' motion for immediate relief in the case captioned *United States v. Georgia*, No. 1:09-CV-119, pending before the Honorable Charles A. Pannell, Jr. That action involves factual and legal issues that overlap with the issues before the Court in the instant action.

The plaintiffs are adults with mental disabilities who have been receiving services under a Georgia Medicaid program called "Service Options Using Resources in a Community Environment ("SOURCE"). (Compl. ¶ 1). Services provided through the SOURCE program include nursing and health-related support services, medically-related personal care and case management. *See* Georgia Department of Community Health, Division of Medical Assistance, *Policies and Procedures for Alternative Living Services*, at XII-29 (attached as Exhibit 4 to Pls.' Mot. for Prelim. Inj., dated Sept. 10, 2010, ECF. No 11-5). In support of their motion, the plaintiffs have put forth substantial evidence that these services have enabled them to remain in their current residential settings and to avoid the recurrent and long term hospitalizations they have experienced in the past. (*See, e.g.*, Pltfs.' Mot. for Prelim. Inj. at 8, 12, 15, 18, 20, 23.) Plaintiffs have also put forth evidence that, without the SOURCE services provided by the State, or sufficient alternative support services, their health will deteriorate and they will be placed in settings, such as hospitals, shelters and jails, that are far more restrictive than their current settings. (*See* Declaration of Dr. Richard Elliott, ECF No. 11-11 ("Elliott Decl.") ¶¶ 34, 42, 60, 69, 75, 77, 96.)

All but one of the plaintiffs have been receiving SOURCE benefits in personal care homes licensed by the State. Personal care homes are one source of

housing for individuals discharged from the State's psychiatric hospitals, but they are not the most integrated setting for most individuals with serious mental illness. Supported housing—another type of service setting that exists (albeit in limited supply) in the State's mental health service system—is an integrated setting in which persons with serious mental illness live in the community and receive flexible support services as needed.[4] *See* Declaration of Michael J. Franczak at ¶ 35, Exhibit 20 to United States' Motion for Preliminary Injunction, *United States v. Georgia*, 09-119 (N.D. Ga. Jan. 28, 2010), ECF No. 55-23 (attached hereto as Exhibit A). Most, if not all, persons with serious and persistent mental illness can be served successfully in supported housing or with similar supports. *Id.* at ¶¶ 9-13.

Plaintiffs' motion is limited to maintaining the status quo to avoid the irreparable harm of unnecessary hospitalizations and deterioration of the plaintiffs' health. For that reason, the United States does not address here whether the defendants are currently serving the plaintiffs in the most integrated settings appropriate to their needs, as required by Title II of the ADA, the Rehabilitation Act and *Olmstead*. Instead, the United States addresses the limited question

[4] The State has already begun to implement Pathways to Housing, a supported housing program modeled after a similar program in New York State. *See* Declaration of Dr. Frank E. Shelp, M.D., Ph.D, ¶ 43, attached as Exhibit 13 to Pls.' Mot. for Prelim. Inj., dated Sept. 10, 2010, ECF No. 11-14.

whether the actions by the defendants that are causing plaintiffs to be at serious risk of unnecessary placement in settings that are more restrictive than their current settings, such as hospitals, shelters, and jails, violates the integration mandate.

Actions that place individuals with disabilities who receive services from the state at serious risk of unjustified institutionalization violate Title II of the ADA and the Rehabilitation Act. *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003). As the facts put forth by the plaintiffs show, defendants' elimination of services, without any alternatives, places the plaintiffs at serious risk of placement in more restrictive settings. Accordingly, the defendants' actions violate the ADA and the Rehabilitation Act, and the Court should grant the plaintiffs' motion for preliminary injunction.

ARGUMENT

I. Olmstead and the Integration Mandate

Congress enacted 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). It found 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). For those

reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o 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.[5]

One form of discrimination prohibited by the ADA is a violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing title II,[6] and the Supreme Court's *Olmstead* decision. In *Olmstead*, the Supreme Court held that unjustified isolation of persons with disabilities is a form of discrimination prohibited by the ADA. *Olmstead*, 527 U.S. at 597. Accordingly, public entities are required to provide community-based services to persons with

[5] Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance").

[6] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. §§ 35.130(d), 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id*. at 607.

A. Institutionalization Is Not A Prerequisite To Establishing A Violation of Title II's Integration Mandate

Defendants assert that plaintiffs do not have standing to bring a Title II claim because they are not currently institutionalized and therefore have not suffered an injury. (Defs.' Resp. at 5.) Defendants' argument is without merit. First, they incorrectly conflate the requirements of Article III standing with the merits of integration claims. The issue here is not whether plaintiffs have "standing." Indeed, defendants do not dispute that the plaintiffs will lose their SOURCE benefits as a result of their change in policy with respect to that program. Plaintiffs therefore have standing because they have alleged injury – *i.e.*, the loss of services – resulting from defendants' conduct. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).[7] At issue in this case whether defendants' conduct violates

[7] *31 Foster Children v. Bush*, 329 F.3d 1255 (2003)—the only case cited by defendants for their proposition that plaintiffs do not have standing—is materially different. There, the Court recognized that "a plaintiff need not demonstrate that the injury will occur within days or even weeks to have standing," but held that

Title II of the ADA, which is a question about the merits of plaintiffs' claims, not justiciability.

Second, Plaintiffs need not wait until they are institutionalized to pursue a claim for violation of the ADA. Neither the statute nor its integration regulation applies solely to institutionalized persons. On the contrary, both protect "qualified individuals with disabilities." 28 C.F.R. 35.130(d); *accord* 42 U.S.C. 12132. Unquestionably, plaintiffs are "qualified individuals," because they are eligible to receive services through the State's program of services for persons with mental disabilities. *See Townsend* v. *Quasim*, 328 F.3d 511, 516 (9th Cir. 2003) (concluding that plaintiff was a "qualified individual with a disability" for purposes of Title II because he was eligible to receive services through State's Medicaid program, he preferred to receive such services in a community-based setting, and community-based services were appropriate for his needs).

Further, the Supreme Court in *Olmstead* recognized Title II's broad prohibition of discrimination goes beyond protecting those who are currently institutionalized. The Court explained that Congress' identification of unjustified

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plaintiffs who were not then in custody of the state could not allege injury for inadequate foster care services. *Id.* at 1266-67. Where, as here, the plaintiffs are currently eligible for and have received support services from the State, the termination of such services that places them at serious risk of institutionalization demonstrates clear injury.

segregation as discrimination "reflects two evident judgments." 527 U.S. at 600. First, that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* And second, that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601. Thus, the goal of the integration mandate is to eliminate unnecessary institutionalization, and requiring a plaintiff to enter an institution before she may bring a Title II claim would defeat this fundamental purpose. *See Fisher*, 335 F.3d at 1181 (reasoning 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.").

Indeed, every court to issue an opinion deciding whether recipients of community-based services may bring an integration claim in such circumstances has agreed that they may do so. *See Fisher*, 335 F.3d at 1181; *Haddad v. Arnold*, No. 3:10-cv-00414-MMH-TEM (M.D. Fla. July 9, 2010) (hereinafter "*Haddad* Op." and attached hereto as Exhibit B) (issuing preliminary injunction requiring

defendants to provide community-based services to plaintiff to prevent unnecessary placement in a nursing home); *Marlo M. v. Cansler*, 679 F. Supp. 2d 635, 637 (E.D.N.C. 2010) (granting preliminary injunction in case where plaintiffs were at risk of institutionalization); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 985 (N.D. Cal. 2010) (granting preliminary injunction where cuts to community-based services placed plaintiffs at risk of institutionalization), *appeal docketed* No. 10-15635 (9th Cir. Mar. 24, 2010). [8]

[8] *See also Ball v. Rogers*, No. 00-67, 2009 WL 1395423, at *6 (D. Ariz. April 24, 2009) (holding that defendants' failure to provide adequate services to avoid unnecessary institutionalization was discriminatory); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,1164 (N.D. Cal. 2009) (granting preliminary injunction where plaintiffs were at risk of institutionalization due to cuts in community-based services); *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009) (preliminarily enjoining cuts to community-based services where plaintiffs demonstrated risk of institutionalization), *appeal docketed*, No. 09-17581 (9th Cir. Nov. 11, 2009); *Crabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506, at *30 (M.D. Tenn. Dec. 19, 2008) ("Plaintiffs have demonstrated a strong likelihood of success on the merits of their [ADA] claims that the Defendants' drastic cuts of their home health care services will force their institutionalization in nursing homes.") *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (ADA's integration mandate applies equally to those individuals already institutionalized and to those at risk of institutionalization); *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999) (holding that individuals in the community on the waiting list for community-based services offered through the State's Medicaid program, could challenge administration of the program as violating Title II's integration mandate because it "could potentially force Plaintiffs into institutions").

B. The Risk of Institutionalization Need Not Be "Imminent"

Defendants' assertion that plaintiffs must show that their institutionalization is "imminent" is similarly without merit. Defs.' Resp. at 5-6. The elimination of services that have enabled plaintiffs to remain out of settings that are more restrictive than their current settings violates the ADA, regardless of whether it causes them to be immediately hospitalized, or whether it causes them to decline in health over time and eventually enter a hospital to seek necessary care. Indeed, in *Fisher*, the first United States Circuit Court case to explicitly recognize risk-of-institutionalization claims, there was no allegation that the defendants' actions threatened any of the plaintiffs with immediate institutionalization. 335 F.3d at 1185. Rather, the evidence showed that many of the plaintiffs would remain in their homes "until their health ha[d] deteriorated" and would "*eventually* end up in a nursing home." *Id.* (emphasis added); *see also V.L.*, 669 F. Supp. 2d at 1120 (concluding that plaintiffs may establish a violation of the integration mandate by showing that the denial of services could lead to an eventual "decline in health" that puts them at "risk [of] being placed in a nursing home.")

As plaintiffs have demonstrated here, their continued stability is highly dependent upon the services that they currently receive through the SOURCE program. (Elliott Decl. ¶¶ 31-33, 41-43, 60, 69, 77, 93-95). The elimination of

those services without any services to replace them puts them at serious risk of placement in more restrictive settings. (Id. ¶¶ 34, 42, 60, 69, 75, 77, 96.)

II. Plaintiffs Satisfy the Requirements for a Preliminary Injunction

To obtain a preliminary injunction, the moving party must show (1) a substantial likelihood of success on the merits, (2) that he will be irreparably harmed in the absence of an injunction, (3) that the balance of the equities favors granting the injunction, and (4) that the public interest would not be harmed by the injunction. *Mesa Air Group, Inc. v. Delta Air Lines, Inc.*, 573 F.3d 1124, 1128 (11th Cir. 2009). The decision whether or not to issue a preliminary injunction lies within the sound discretion of the trial court. *Charles H. Wesley Educ. Foundation, Inc.* v. *Cox*, 408 F.3d 1349, 1354 (11th Cir. 2005). The "primary justification" for the issuance of a preliminary injunction is to preserve the court's ability to render a meaningful decision on the merits. *Canal Authority of the State of Florida v. Callaway*, 489 F.2d 567, 573, 576 (5th Cir. 1974).[9] Here, preliminary injunctive relief is necessary to prevent the irreparable harm of unnecessary and

[9] *See also Cox*, 408 F.3d at 1351 (affirming preliminary injunction in a voting rights acts case requiring defendants to process voter registration applications); *Gresham* v. *Windrush Partners, Ltd.*, 730 F.2d 1417, 1425 (11th Cir. 1984) (issuing preliminary injunction requiring defendants to display notices and instruct employees and agents of nondiscrimination policies and finding that "when housing discrimination is shown it is reasonable to presume that irreparable injury flows from the discrimination"); *Haddad* Op., at 39 (issuing preliminary injunction requiring defendants to provide community-based services to plaintiff);

repeated institutionalization in a psychiatric hospital caused by defendants' termination of services. *See Long* v. *Benson*, No. 08cv26, 2008 WL 4571903 *2 (N.D. Fla. Oct. 14, 2008) (granting preliminary injunction requiring Florida to provide Medicaid-funded community-based services because irreparable injury would result if plaintiff were forced to enter a nursing home), *aff'd*, No. 08-16261, 2010 WL 2500349 (11th Cir. June 22, 2010).

A. Plaintiffs Are Likely to Succeed on the Merits

To establish a violation of Title II of the ADA, a "plaintiff must prove that (1) she has a disability; (2) she is a qualified individual; and (3) she was subjected to unlawful discrimination because of her disability." *Morisky v. Broward County*, 80 F.3d 445, 447 (11th Cir. 1996).[10] Defendants do not dispute that plaintiffs are persons with disabilities within the meaning of the ADA and the Rehabilitation Act. Nor do they dispute that plaintiffs are eligible to receive services in the State's mental health service system. Instead, defendants contend that plaintiffs fail to meet the eligibility criteria of the SOURCE program because "they do not meet the program requirements which have been set forth legitimately by [the defendants]." Defs' Resp. at 10. Defendants also assert that continuing to provide

[10] Claims under the ADA and the Rehabilitation Act are treated identically unless, unlike here, one of the differences in the two statutes is pertinent to a claim. *Allmond v. Akal Sec., Inc.*, 558 F.3d 1312, 1316 n.3 (11th Cir. 2009); *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003).

SOURCE services to the plaintiffs would be a fundamental alteration of that program. *Id*. at 11. These arguments are without merit.[11]

1. Plaintiffs Are Qualified Individuals with Disabilities

Under the ADA, a "qualified individual with a disability" is "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices … meets the essential eligibility requirements for receipt of services or the participation in programs or activities provided by the public entity." 42 U.S.C. § 12131(2). The defendants argue that plaintiffs are not eligible for the SOURCE program because the defendants have implemented practices that exclude plaintiffs from that program. The relevant program for purposes of this analysis, however, is not the SOURCE program, which the State is now

[11] Defendants raise an additional argument that "[t]o the extent that Plaintiffs are utilizing the regulation relied upon as the vehicle for this suit, no private right of action exists in such a regulation promulgated to implement the ADA." Defs.' Resp. at 9. This argument misconstrues plaintiffs' claims. Plaintiffs are not relying solely upon the ADA regulations as the basis for their action. Rather, they are alleging a violation of Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132. Accordingly, *American Association of People with Disabilities v. Harris* ("AAPD"), 605 F.3d 1124 (11th Cir. 2010) is inapplicable here. In *AAPD*, the court found that there was no legal basis for an injunction because the district court's ruling did not hold that the defendants had violated the ADA, instead it ordered the defendant to comply with the regulation alone. 605 F.3d at 1131. The *AAPD* court's entire analysis considers whether the regulation provides "a freestanding cause of action." However, no freestanding cause of action is being alleged in this case. *See also Haddad* Op. at 25-26 (holding that *AAPD* presents no bar to the plaintiff's integration claims where she is asserting a violation of the ADA).

administering in a way that excludes plaintiffs. The relevant program is the State's program of services for persons with mental disabilities, which includes community-based services funded by SOURCE and other means, as well as services provided in institutions. Defendants do not dispute that plaintiffs are eligible for and do receive services in the State's mental health service system. The State is required to provide those services in the most integrated setting appropriate to the needs of the plaintiffs. Given that plaintiffs have been successfully served with support services in their current settings, there can be no dispute that they are qualified to remain in those settings with adequate services.

2. Plaintiffs' Current Level of Services Can Be Maintained With Reasonable Modifications to the State's Service System

With reasonable modifications to its service system, the State could maintain the services necessary to enable plaintiffs to avoid unnecessary hospitalizations. Given that the plaintiffs have been receiving services in their current settings for almost two years, it is clear that a service delivery system is already in place and that plaintiffs are connected to a network of caregivers. Indeed, defendants have failed to muster any support for their assertion that the relief sought would "effect an entire reworking of the SOURCE program and would represent a significant alteration to that program." Defs' Resp. at 11.

Moreover, as defendants do not dispute, it is far less costly to serve individuals with disabilities outside the setting of a psychiatric hospital or other similar settings. *See* Georgia Department of Community Health, Division of Medical Assistance, *Policies and Procedures for Service Options Using Resources in Community Environments* at VI-1-2 (attached as Exhibit 5 to Pls.' Mot. for Prelim. Inj., dated Sept. 10, 2010, ECF. No 11-6) (stating that the SOURCE program was created "to reduc[e] the need for long-term institutional placement and increas[e] the cost-efficiency and value of Medicaid [Long-term Care] funds by reducing inappropriate emergency room use, multiple hospitalizations, and nursing home placement caused by preventable medical complications.").

Defendants could also pursue other options for obtaining federal funding for services they provide to persons with mental disabilities. Partial federal funding could be available through the Medicaid program, either through rehabilitative or personal care benefits available under the State Medicaid plan, through a home and community-based services program established in the State plan under Section1915 (i) of the Social Security Act, [12] or, when Medicaid would

[12] Under Section 1915(i), States can provide home and community-based services through a state plan service package that does not require that recipients meet the nursing home level of care. Under the Affordable Care Act, P.L. 111-148 & P.L. 111-152, States are now permitted to target specific 1915(i) services to State-specified populations. *See* State Medicaid Director Letter, Re: Improving Access

otherwise cover institutional care, through a program to furnish home and community-based services operating under a waiver of Medicaid requirements pursuant to section 1915(c) of the Social Security Act.[13]

The plaintiffs thus have a substantial likelihood of success on the merits of their claims.

B. Plaintiffs Will Suffer Irreparable Harm Without Injunctive Relief

Without a preliminary injunction preserving the status quo, the plaintiffs will suffer irreparable harm. The plaintiffs' medical expert has determined, based on his assessments of the plaintiffs, that the loss of their current services would result in the deterioration of their health and will require them to endure frequent hospitalizations, long-term institutionalization, or incarceration. (Elliott Decl. ¶¶ 31-33, 41-43, 60, 69, 77, 93-95). Thus, the harm the plaintiffs will endure is not speculative and cannot be adequately remedied by a later decision from this Court.

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to Home and Community-Based Services, August 6, 2010, available at http://www.cms.gov/smdl/downloads/SMD10015.pdf.

[13] Although the State argues that it terminated SOURCE services to plaintiffs because of federal limitations of its existing Medicaid waiver programs, that argument is flawed. Defendants' obligations under *Olmstead* are not defined by, or limited to, the scope of the Medicaid program. The Medicaid program provides an opportunity for the State to obtain partial federal funding to provide services, but the obligation of the State to ensure that individuals with disabilities are not needlessly institutionalized is independent of the Medicaid program. Even if the plaintiffs were not properly served in a particular Medicaid waiver program, the defendants could construct their program in a way that complies with both Medicaid and the ADA.

As many courts have held, requiring an individual to submit to unnecessary institutionalization in order to receive needed services results in irreparable harm. *See Marlo M.*, 679 F. Supp. 2d at 638 (finding that unnecessary instutitonalization constitutes irreparable harm and recognizing the "regressive consequences" that such placements would have on the individuals); *Crabtree*, 2008 WL 5330506, at *25 (finding that unnecessary institutionalization "would be detrimental to [plaintiffs'] care, causing, inter alia, mental depression, and for some Plaintiffs, a shorter life expectancy or death"); *Long*, 2008 WL 4571903, at *2 (finding irreparable harm where individual would be forced to leave his community placement and enter a nursing home and specifically recognizing the "enormous psychological blow" that such placements would cause). The disruptive and destabilizing effects of repeated hospitalizations or long-term entry into an institution cannot be understated.[14]

C. <u>The Balancing of Hardships Tips in Plaintiffs' Favor</u>

The hardship to defendants of continuing to provide services to the six plaintiffs in this action is negligible, and is unquestionably outweighed by the benefit of allowing plaintiffs to avoid placement in more restrictive settings.

[14] The plaintiffs also face the substantial possibility of losing their current housing. For example, Mr. Knipp has received an eviction notice from his personal care home because he did not prevail on his administrative appeal to retain his SOURCE benefits. (Second Declaration of Ray Johnson ¶ 2).

Long, 2008 WL 4571903 at *3 (N.D. Fla. Oct. 14, 2008) ("If, as it ultimately turns out, treating individuals like [the plaintiff] in the community would require a fundamental alteration of the Medicaid program, so that the Secretary prevails in this litigation, little harm will have been done. To the contrary, [plaintiff's] life will have been better, at least for a time."). Providing services to the plaintiffs in manner that prevents their institutionalization in a psychiatric hospital will also *save* defendants money. *See* p. 17 *supra*. The lack of hardship to defendants stands in stark contrast to the significant hardship the plaintiffs face if no injunction is granted.

D. Granting a Preliminary Injunction is in the Public Interest

The public interest weighs heavily in favor of granting preliminary injunctive relief. There is a strong public interest in eliminating the discriminatory effects that arise from segregating persons with disabilities into institutions. As the *Olmstead* Court explained, the unjustified segregation of persons with disabilities stigmatizes them as incapable or unworthy of participating in community life. *Olmstead*, 527 U.S. at 600. Many courts have held that issuing injunctive relief to avoid unnecessary institutionalization furthers the public interest. *See Long*, 2008 WL 4571903, at *3; *Haddad* Op. at 38 ("[T]he public interest favors preventing the discrimination that faces Plaintiff so that she may avoid unnecessary

institutionalization … [and] upholding the law and having the mandates of the ADA and Rehabilitation Act enforced….”); *Wagner*, 669 F. Supp. at 1122 (preliminary injunction enjoining the state from withdrawing community-based supports furthers the public interest); *Cota*, 688 F. Supp. 2d at 999 (preliminary injunction enjoining the state from implementing restrictive eligibility requirements for community-based services was in the public interest); *Kathleen S. v. Dep’t of Pub. Welfare*, 10 F. Supp. 2d 476, 481 (E.D. Pa. 1998) (“[I]t is clearly in the interest of the public to enforce the mandate of Congress under the Americans with Disabilities Act.”) Thus, granting a preliminary injunction in this matter to prevent the withdrawal of support services is in the public interest.

CONCLUSION

For all the foregoing reasons, the Court should grant Plaintiffs' Motion for Preliminary Injunction. The United States respectfully requests to be present, through its counsel, at the hearing on plaintiffs' motion for preliminary injunction.

Dated: October 6, 2010

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The undersigned counsel certifies that the foregoing document was prepared in Times New Roman 14 point font, in compliance with L.R. 5.1.B.

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CERTIFICATE OF SERVICE

This is to certify that I have on this day electronically filed the foregoing STATEMENT OF INTEREST OF THE UNITED STATES with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all parties in this matter via electronic notification or otherwise:

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This 6th day of October, 2010.

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Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:09-CV-119-CAP
THE STATE OF GEORGIA; et al.	)	
	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MICHAEL J. FRANCZAK

Pursuant to 28 U.S.C. § 1746, I, Michael J. Franczak, do hereby declare:

Background and Expertise

1. I am a licensed psychologist and Chief of Operations for Behavioral Health Services at the MARC Center in Mesa, Arizona. The MARC Center provides behavioral health, developmental disability, and vocational services to over 3,000 individual clients. The MARC Center also provides community services to 4,000 adults with serious mental illness and co-occurring disorders through Partners in Recovery, an LLC.

2. I currently serve as an expert consultant to the United States Department of Justice in monitoring the State of Georgia's compliance with a settlement

agreement (the "Agreement") in United States v. Georgia, Case No. 1:09-cv-00119-CAP (January 15, 2009), concerning the seven State Psychiatric Hospitals ("State Hospitals"). Before entry of the Agreement, I served as the United States' expert consultant in its investigation of the State Hospitals.

3. I have extensive experience and professional expertise as both an administrator and a clinician providing behavioral health care services for individuals with serious mental illness, developmental disabilities, and/or co-occurring substance abuse disorders, in both institutional and community settings. For the past 15 years, I have been a senior executive responsible for administering behavioral health services through state and private providers. For five years, I served as the Chief of Clinical Services for the Arizona Department of Health Services, Division of Behavioral Health Services, where I was responsible for the organization, development, and direction of the statewide clinical infrastructure and operations for the Division of Behavioral Services where we served over 90,000 individuals in institutional and community settings.

4. I have served as an expert to a number of court monitors and court special masters overseeing legal agreements governing all aspects of care provided

in both institutional and community settings to residents with developmental disabilities and to persons with mental illness. Examples of such cases include Arnold v. Sarn, No. C-432355 (Sup. Ct. Maricopa Co. 1999), Johnson v. Bradley, No. 99-13458 (M.D. Fla.), U.S. v. Tennessee, No. 92-2062 (W.D. Tenn.), Lelsz v. Kavanaugh, No. 86-1166 (5th Cir. 1987), and New York State Ass'n for Retarded Children v. Cuomo, No. 82-7441 (E.D.N.Y.). I have been accepted as an expert witness in federal court, offering testimony on the issues of behavior management, interdisciplinary process, and applicable standards of care in Jackson v. Fort Stanton Hosp. and Training School, No. 91-2027 (10th Cir. 1992). I have served as an expert witness in numerous additional cases in federal court, although my courtroom testimony was not required in those additional cases.

5. I have authored publications on topics including program accountability, crisis assessment procedures, behavior management, behavior modification, treatment strategies for the dually diagnosed, quality assurance in community services, vocational services, the role of employment in recovery, and integrated mental health and substance abuse treatment. My curriculum vitae is attached as Attachment A.

6. In my role as expert consultant to the Department of Justice in this case, I have examined the treatment and discharge and transition planning services provided to individuals in the State Hospitals, and the availability of services in the community before and after an admission to a State Hospital. My review has included the following:

a. On-site inspections of the following State Hospitals: Georgia Regional Hospital at Atlanta on September 17-21, 2007, Northwest Georgia Regional Hospital in Rome on October 29 through November 2, 2007, Georgia Regional Hospital at Savannah on December 17-21, 2007 and again on June 22-26, 2009, West Central State Hospital on November 30 through December 3, 2009, and Central State Hospital in Milledgeville on November 2-6, 2009 and again on January 11-15, 2010. A representative sample of the interviews and meetings attended and documents reviewed on site can be found at page 109 of the compliance report for the June 2009 Savannah inspection, attached to the United States' Motion as Exhibit 4;

b. Evaluation of the State's policies and procedures, and, as applicable, individual hospital policies, procedures and protocols;

c. Review of the clinical records of hundreds of individuals in the State Hospitals;

d. Interviews with administrators, clinical staff, direct care staff, and the individuals who reside in the State Hospitals;

e. Interviews with the State's Director of the Office of Transitional Planning, and the State's Olmstead Coordinator;

f. Review of summary data and analysis of admissions and readmissions to the State Hospitals, both data generated by the separate State Hospitals and by the State Department of Behavioral Health and Developmental Disabilities ("DBHDD" formerly referred to as the Department of Mental Health, Developmental Disabilities and Addictive Diseases);

g. The State's February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); the January 2005 Study of the CSB Service Delivery System (Phase II); and the May 2005 Georgia Mental Health System Gap Analysis; and survey reports by the Medical College of Georgia from 2007 for each of the hospitals visited;

h. Review of the State's proposed draft Plan of Implementation for the Agreement, and participation in a day-long meeting concerning that plan with the Department of Justice, the attorneys for the State, representatives of BDHDD, and representatives of the Advocacy organizations who have voiced objections to this Court about the deficiencies in the Agreement;

i. The draft proposed Olmstead Behavioral Health Initiative Five-Year Community Finding Plan (December 2009);

j. Interviews with advocates and family members of persons with mental illness in Georgia; and

k. Interviews with the operators of emergency shelters who frequently shelter patients discharged from the State Hospitals.

Individuals Served by the State Hospitals

7. The State Hospitals provide services to persons with serious mental illness, developmental disabilities, and substance abuse disorders. A number of individuals have co-occurring diagnoses of both mental illness and developmental disability. A large number of individuals whose records I reviewed also had a co-occurring substance abuse history. By my estimate, perhaps as many as half of the records I reviewed of persons with mental

illness also had a substance abuse history, which is consistent with data estimates nationally. Many of the individuals served by the State Hospitals have additional physical disabilities or medical concerns. For all of these individuals, participation in major life activities, such as living independently, maintaining a household, holding a job, or taking medication to manage their illness is substantially limited by their psychiatric disabilities. In some cases, these individuals are also limited because others perceive them to be limited by these disabilities.

Expert Opinion

8. My expert opinion, based on my 38 years of experience in the field of behavioral health care and on my review of the systems of care in the Georgia State Hospitals, is that the transition and discharge planning process in the State Hospitals departs substantially from generally accepted professional standards of care, as described more completely below. In addition, the lack of an adequate community service system with a full array of necessary services and supports requires many individuals to be hospitalized to obtain services that can be – but are not – made available to them in a community setting. Thus, individuals with disabilities, including mental illness or developmental disabilities, who desire to live in the

community and whose treatment professionals believe that they can, are not able to obtain the services necessary to live in the community.

Individuals Are Inappropriately Institutionalized

9. Many individuals whose records I reviewed have been institutionalized because sufficient community services were not available to address their needs before admission. The hospitals appear to function as first responders to mental health crises because there appear to be insufficient community and mobile crisis services in the State to stabilize people in crisis without resort to hospitalization. It is my experience that in most states, many of these individuals experiencing short term crises would not have to be hospitalized.

10. There are similarly too few crisis and community support services for individuals with developmental disabilities, many of whom are re-institutionalized due to short-term crises that could have been stabilized in the community. For example, one individual with a developmental disability who had enjoyed a community placement was readmitted to a State Hospital, according to his records, because "there was no where for him to remain in the community" during an investigation of possible caregiver abuse following an incident.

11. Many other individuals whose records I reviewed were admitted repeatedly to the hospital, typically for brief periods, received neither adequate treatment nor adequate discharge and transition planning, and were released, only to be re-admitted in weeks or months. These individuals, often referred to as the "revolving door" population, have typically been institutionalized dozens of times in a period of a few years. Incredibly, many have been re-admitted more than 100 times to the State Psychiatric Hospitals. With adequate treatment and discharge planning, and with expanded availability of services in the community, this cycle of needless repeated institutionalization could be avoided. The individuals caught in the revolving door of repeat admissions are at significant risk of harm, both from the aggression and self-injury so prevalent in the State Hospitals, but also because repeated cycling in and out of crisis and in and out of the hospital can make their illness more intractable to treatment.

12. Institutionalization is stigmatizing. It is also extraordinarily disruptive of relationships, employment, school and all aspects of building a life in the community to be unnecessarily institutionalized.

13. All individuals inappropriately institutionalized face ongoing and significant harm. Many of those who are institutionalized and deprived of their liberty

do not receive necessary and appropriate care. Finally, all patients in the State Hospitals face a significant risk of bodily harm from assault and self-injury that is so prevalent in the State Hospitals.

The State Has No System to Ensure That Individuals Receive Services in the Most Integrated Setting Appropriate to Their Needs

14. The State's process for identifying patients able to transition from the State Hospitals is needlessly cumbersome and fundamentally flawed. The State's policies do not require systematic evaluation of all individuals in the institutions to ensure that they are being served in the most integrated setting appropriate to their needs unless they have been institutionalized for 60 days or longer. The way the process works in Georgia, the State begins developing a transition plan only after an individual's treatment team identifies him or her as appropriate for treatment in a more integrated setting. This system is exactly backwards. To ensure that individuals receive care in the most integrated setting appropriate to their needs, it is important to begin to identify, as soon as possible after admission, the specific community resources that are needed to support the individual in a more integrated setting. That is accomplished by creating an interdisciplinary transition plan. Tracking how long individuals wait in the State Hospitals before they are placed on the list to be transitioned to the

community can also force accountability for needless delay – but in Georgia, the State does not systematically track, analyze and report this data.

15. Individuals with mental illness face a double barrier to discharge under this systemically flawed process. Many individuals with mental illness, particularly those who are repeatedly admitted for very short lengths of stay, may never receive an interdisciplinary review centered on what supports and services are required to support them in a more integrated setting because the State does not require such a review until the individual has been hospitalized for 60 days.

16. The State has determined, as a matter of policy, that all persons with developmental disabilities can be served in the community or a more integrated setting than the State Psychiatric Hospitals. The State's Director of the Office of Transition Services stated that, unless a person with a developmental disability or his or her family objects, they are placed on the Olmstead lists right away. Many individuals with developmental disabilities, however, have spent additional months and years waiting to be placed in the community after being placed on these lists.

17. In my experience, all of the individuals I have described, including those with developmental disabilities or with mental illness, those who have been

institutionalized for long periods, and those who make up the "revolving door" of frequent admissions, could be served successfully in the community with a range of community-based supports and services typically available in other states.

Discharge and Transition Planning Services at the State Hospitals Depart Substantially From Generally Accepted Professional Standards

18. The discharge and treatment planning services provided to patients in the State Hospitals are systemically flawed, and depart substantially from generally accepted professional standards. The State Hospital System does not set a uniform standard for quality of care. Although policies espouse a person-centered philosophy of care, in fact, the care provided across the system is based on an antiquated model of care that is not recovery oriented and in many cases fragmented by the lack of community resources and poor coordination between institutional and community care. Training and quality assurance is deficient and fails to detect and correct overwhelming instances of substandard care.

19. Accurate assessments are needed to identify the reasons that individuals have been hospitalized and to guide treatment interventions, particularly in the case of those individuals readmitted after a prior admission and discharge. Yet assessments I reviewed are frequently generic and

incomplete and fail to result in a comprehensive or coherent case formulation. Assessments from different disciplines are often contradictory, and differences are not resolved by the treatment teams because the teams do not function in an interdisciplinary manner.

20. Treatments are not adequate to address the needs of individual patients. The State Hospitals provide the majority of treatment interventions in treatment malls, or, for individuals with developmental disabilities, in training centers on the grounds of the Hospitals. Having reviewed these programs at each of the hospitals visited, it is my opinion that treatment is woefully inadequate to address the needs of individuals in the State Hospitals, and falls substantially short of generally accepted professional standards. The barriers to successful community living are not routinely addressed in treatment for any of the populations served by the State Hospitals. Treatment seems to be based primarily on what groups are available, and not on what skills individuals need to learn to facilitate their recovery and prepare them for life outside the hospital.

21. Staff need training in critical areas, including person-centered treatment planning that supports development of an integrated treatment plan. Individuals in the State Hospitals with acute psychiatric needs typically

receive only the most generic interventions and treatments, primarily focused on medication stabilization. Groups and interventions are not aligned with the recovery model that the State professes to be its model of care. There is a need to focus on developing skills, and on identifying strengths of the person to build upon. A treatment plan I examined at one hospital stated simply, "this patient has no strengths."

22. There is an egregious lack of substance abuse treatment for individuals who have a history of substance abuse, both in the State Hospitals and in the community. Individuals with a history of substance abuse are among those patients who are frequently re-admitted to the State Hospitals and they represent a significant portion of the individuals treated in the State hospital setting. For example, one individual at GRHS with a history of mental illness and cocaine dependence had been admitted more than 100 times to the State Hospitals, typically for very short periods of several days. His discharge plan was that "He will go wherever he goes," and his prognosis was: "Expect a repeat of this situation in a week."

23. Treatment teams do not engage in person-centered planning. The individual's desires, and those of his or her chosen representative, are not central to the treatment or discharge plan. The State Hospitals fail to engage

family members or significant others in the treatment planning or discharge process. I saw no evidence that family members who could provide the needed natural supports for individuals living in the community are provided with educational materials or supports to assist their loved ones upon discharge.

24. A Repeat Admissions Review Coordinator ("RARC") has been established at several of the hospitals that I visited, and the RARC has begun to identify forms and processes to guide the review of patients re-admitted to the Hospital after a prior admission. Nonetheless, the use of information about reasons for re-admission remains substantially deficient. For example, at CSH, where the RARC has identified processes and provides helpful reports to treatment teams, the information presented by the RARC does not influence treatment planning in 60% of the cases reviewed.

25. A central principle of transition planning is ensuring continuity of care from the hospital to the community. However, the State Hospitals fail to document sufficient efforts to engage community providers in developing a transition plan, or to connect individuals with community services prior to discharge.

26. Policies at the State Hospitals, for example, Central State Hospital ("CSH") Policy 4.31, address Continuity of Care and Transition Planning. This policy requires the State Hospital to make only minimal efforts to engage the community in the discharge process, which severely compromises the quality of care provided upon discharge. Minimal, and frequently, non-existent participation of community providers results in transitions where individuals have had no prior contact with the community provider, in violation of generally accepted professional standards. I also saw no indication in any of the records of persons re-admitted to CSH that the Hospital maintained communication with the providers or the individual after discharge to the community.

27. The State Hospitals do not provide adequate information about the individuals who have been under their care to community providers at the time of discharge. The State Hospitals should exist as part of a continuum of care, and must transfer the information they gain about hospitalized individuals, their strengths, needs, learning styles and preferences, to the community providers who next provide care. To the individual patient, the transition from institutional to community care should be seamless.

28. The State Hospitals continue to discharge large numbers of individuals to night shelters, transportation terminals, and the public buildings and streets, although these and other similarly inappropriate settings lack the necessary programs to support individuals with serious mental illness or substance abuse problems. I have spoken with the operators of shelter programs who assert that individuals discharged from the State Hospitals typically arrive without any advance notice or a phone call from the Hospital. Discharged patients arrive with no support other than a short term prescription for anti-psychotic medications. The shelter operators with whom I spoke were willing to provide shelter, but noted that they did not, and could not, provide the supports and services often needed by a person with serious mental illness, including services such as assistance in taking medication or managing medical and mental health care appointments.

29. I have seen no documentation to suggest that the State Hospitals adequately counsel individuals or sufficiently describe or offer appropriate alternatives to individuals who choose discharge to a homeless shelter.

30. Inappropriate discharges place the affected individuals at risk of significant harm. In one case last fall, an individual who was three months pregnant was discharged to a homeless shelter, with multiple prescriptions but no

connection to a medical care provider or other necessary behavioral supports. In a second case, an individual with ten prior admissions to the State Hospitals was discharged to a shelter. Within two days he apparently took an overdose of medication, possibly as a suicide attempt. On readmission to the State Hospital, he made clear his pressing needs: he did not want to go back to a shelter, and needed the Hospital to help him find a place and fix his social system.

31. I saw little documentation to suggest that the State Hospitals take sufficient steps to educate family members or personal guardians who object to community placement about positive outcomes and choices available in the community. Generally accepted standards require education of individuals and their personal representatives to overcome opposition based on outdated or mis-information about the choice of services that are currently available to support an individual in more integrated settings.

32. Typically, Social Workers in the hospitals asserted to me that choice counseling and family education is done by case expediters or other staff who work for the Regional Offices of DBHDD. Yet the State Hospitals could offer no documentation to support that assertion. In individual cases I discussed with hospital Social Workers, it was evident that long delays in

placement occurred because State or Regional Office employees and others outside the Hospital's control failed to follow up as promised. In many instances, it appeared that community placements were not identified as promised, and in other cases, it appeared that opposition from family or personal representatives was not addressed and overcome. The result is that individuals who have been identified by treatment professionals as appropriate for community placement remain hospitalized for long periods following that determination.

There is an inadequate array of community services

33. Because the State has failed to develop and fund an adequate array of community services, individuals with serious mental illness, developmental disabilities and/or substance abuse disorders in the State of Georgia continue to be confined unnecessarily.

34. The audits done by the State of its community service boards pointed to significant gaps in necessary services and a lack of accountability in the community system.

35. Insufficient supported housing opportunities in the State result in individuals having to reside in inappropriate settings that do not support their recovery and their return to the community.

36. The State's lack of assertive community treatment or intensive case management services causes individuals to have to be hospitalized when they are not adherent to their medication regimes. These services, which are inadequate in Georgia, are effective because they can improve medication adherence and prevent hospitalization. An intensive staffing ratio of 1:12 allows more intensive supervision for persons who require this level of care. An assertive community treatment ("ACT") team typically costs at least $1.2 million for one year. It was clear from my review of records that many individuals with mental illness in the State Hospitals need assertive community treatment upon discharge, but do not receive this service. Professional staff at each of the hospitals I visited agreed that there are insufficient ACT teams to serve the people who need them.

37. There is an inadequate array of community crisis intervention services and mobile crisis intervention services to address short-term intensive needs and allow individuals to remain in the community instead of being hospitalized.

38. Although the State has a nationally-acclaimed model of peer supports, this service is not routinely available in the hospital or community.

39. There are very limited day treatment or partial-hospitalization programs that provide individuals with the skills needed to be successful in the community.

40. There are vastly insufficient vocational services and supports that would allow individuals to gain self-esteem by becoming productively employed members of their community.

41. Unnecessary and prolonged institutionalization harms the individuals who are confined. Being confined to an institution is extraordinarily disruptive of life in the community, of personal relationships, of living arrangements, and of employment. In addition, repeated admission without successful treatment can worsen an individual's illness, as research shows that frequent relapse and re-admission may make an individual more intractable to treatment.

Cost of Providing Services in the Community

42. In my experience, providing services to support a person with mental illness or a person with a developmental disability living in the community costs substantially less than providing services in an institutional setting. The figures used in Georgia's draft Olmstead Behavioral Health Initiative Five-Year Community Funding Plan support this, suggesting a cost savings of more than $13,000 per person when serving a person with mental illness in the community.

Keeping Individuals Safe

43. Individuals in the State Hospitals – including the many individuals who should never have been hospitalized and for whom the hospital is not the most integrated setting in which to receive care – face an ongoing risk of serious harm. At each hospital, lengthy lists of incidents involving assaults and injury were provided to the expert team. Both victims and aggressors on these list are suffering harm – the aggressors, because they are denied competent and effective care to address the symptoms of their illness, and the victims, by their injuries. There is no system in place to ensure timely and effective intervention when patients engage in repeated or escalating episodes of aggression or self-injury. Staff do not display competency in using generally accepted techniques to modify challenging or dangerous behaviors, including the use of functional behavioral analysis and positive behavioral supports. There is insufficient evidence-based treatment provided at the State Hospitals, and insufficient trained staff to provide it.

44. I am aware that the settlement agreement between the United States and the State requires substantial efforts to reduce patient assaults no later than January 15, 2010. During my visit to CSH from January 11-15, new state-level risk management policies were described that would create a system to detect individuals with escalating signs and symptoms of

aggression and other behavioral concerns, and require treatment teams to address those concerns. There is no evidence that the system has been implemented.

45. Staff are not trained adequately to implement the new policies described to the DOJ team on our visit to Central State Hospital ("CSH") in January. I interviewed the director of staff training at CSH, and requested the plans developed to train all employees in the coming months, including all plans for training on the revised policies. The training plans are not sufficient to

address the significant training needs evident at CSH and in each of the hospitals I visited, and certainly not within the promised time frames.

* * * * *

The foregoing is based on my professional expertise, and also my personal knowledge of conditions and policies governing treatment planning, and discharge and transition planning at the State Psychiatric Hospitals, gained through my examination of documents including clinical records, my observations, and interviews with hospital staff, patients, and administrators, State administrators and employees, and community- based service providers.

I certify under penalty of perjury that the foregoing is true and correct.

Executed this 28th day of January, 2010.

MICHAEL J. FRANCZAK

Attachment A

RESUME

MICHAEL J. FRANCZAK, Ph.D.
9124 East Maple Lane
Scottsdale, Arizona 85255
(480) 473-3397

EDUCATION:

1974-1976	Saint Louis University, Saint Louis, MO Ph.D. in Psychology May 1976
1972-1974	New School for Social Research, New York, NY
1971-1972	Montclair University, Montclair, NJ M.A. in Psychology, December 1972
1967-1971	LaSalle University, Philadelphia, PA B.A., May 1971, Major: Psychology

PROFESSIONAL ACTIVITIES

December 2006 to Present:
Chief Operations Officer for Behavioral Health Services, Marc Center Mesa, Arizona.

In this position I am responsible for the organization, development and direction of services for individuals who receive behavioral health services through Marc Center. Marc Center has been in existence since 1957 providing behavioral health, developmental disability and vocational services to both children and adults. The Marc Center behavioral health program provides residential, independent living, outpatient services, vocational services, in-home and recovery supports. We have a staff of over 300 who provide these services 24/7. Our current budget is approximately $14,000,000. Due to our wide variety of services and excellent national reputation, Marc Center serves as a training site for Council for the Accreditation of Rehabilitation Facilities (CARF) Reviewers.

February 2001 to November 2006:
Chief of Clinical Services, Arizona Department of Health Services, Division of Behavioral Health Services, Phoenix, Arizona.

In this position I was responsible for the organization, development and direction of the statewide clinical infrastructure and operations for the Division of Behavioral Health Services. The total budget for the Division is approximately $950,000,000. Clinical operations include the Bureau's for Adult Services, Children's Services, Substance Abuse Services, Prevention, Training, Customer Services and Network Management. Responsibilities include the management of the programmatic monitoring and oversight of the Regional Behavioral Health Authorities (RBHA) to ensure compliance with state and federal programmatic requirements, standards and guidelines; development, monitoring and implementation of corrective action plans; developing budgets and monitoring clinical services expenditures; coordination of activities among Division clinical bureaus and other offices of the Division of Behavioral Health; provision of training, technical assistance and consultation to the RBHA; development of clinical policies and procedures to ensure compliance with federal and state regulations; development and monitoring of transition and discharge processes from State and Local Psychiatric facilities to the community behavioral health system including admissions and readmissions, development of reports for and testimony at Legislative hearings, writing federal grants including the State Block grant and other competitive grants, serving as the Chairperson for statewide committees on Olmstead Planning, Best Practices, Stigma Reduction, Assessment and Evaluation, Data Integrity, Clinical Services, Co-Occurring Disorders, and Network Analysis and Development.

January 1995 to February 2001:
Chief, Bureau for Persons with Serious Mental Illness, Arizona Department of Health Services, Division of Behavioral Health Services, Phoenix, Az.

In this position I managed the services provided by the Bureau for Persons with a Serious Mental Illness. The Bureau monitored services for 22,000 individuals throughout the State of Arizona. In this position I was responsible for the development, implementation and monitoring of a community system of care including the transition and discharge process from State and Local Psychiatric facilities to the community behavioral health system including admissions and readmissions. The Bureau activities included oversight of contract performance, implementation of system improvements, provision of technical assistance and training and coordination of a variety of grant activities. The Bureau was involved in the Division of Behavioral Health's Planning Councils, a variety of work groups including Jail Diversion, Social Security Work Incentives, and a variety of consumer and recovery support activities.

July 1991 to December 1994:
Senior Research Associate; Improvement Concepts Incorporated; Raleigh, NC

In this position, I served as the manager of Improvement Concepts (ICI) North Carolina office from which evaluations of potential Thomas S. class members were organized and conducted. ICI was appointed as the Independent Evaluator by the Federal District Court for the Thomas S. case. The class membership was estimated to be 2,300 individuals, the majority of whom lived in State Mental Hospitals, Nursing homes, Group Homes, ICF/MR's and Private Boarding Homes. The potential class members were individuals who have a mental health and mental retardation diagnosis and had received treatment in mental health settings operated by the state of North Carolina. In this position I developed and tested evaluation instruments, trained and supervised the independent evaluators used in this case. The evaluation instruments were based on relevant HCFA regulations, ACDD standards, and state and federal regulations. The evaluations resembled internal quality assurance reviews and focused on habilitation, living conditions, medication practices, and behavioral interventions. A large section of the evaluations included recommendations to improve services for the individual based on the requirements of the court order. There were at least 40 independent contractors conducting evaluations. I also provided follow-up on the review and disposition of the evaluations and testimony as necessary.

November 1990 - July 1991:
Director of Planning, Evaluation, and Development/Quality Assurance; Western Center; Canonsburg, PA

In this position, I directed the facility quality assurance and professional services program. I was assigned by the Pennsylvania Director of Health Services to Western Center which served individuals with developmental disabilities and behavioral health issues on an emergency basis following financial sanctions that were placed on the facility by the Health Care Finance Administration. My job was to get the facility back to full licensure. Within six months, the facility received a full license and had all sanctions removed. Following the emergency assignment, I remained at the facility in order to further structure their quality assurance program to ensure sustainability. Full license was attained and maintained during my tenure at Western Center.

June 1983 - November 1990:
Director of Planning, Evaluation, and Development/Quality Assurance; Laurelton Center; Laurelton, PA

Laurelton Center provided services to children, adolescents and adults with developmental disabilities and behavioral health disorders and served as the site for regional special education program that served children living at Laurelton, with family and in other residential settings in the Central Pennsylvania region. In this position, I directed and reviewed all aspects of the facility's quality assurance activities. This included program management audits, internal compliance reviews, privacy audits, safety inspections, infection control inspections, supervisory inspections, QMRP reviews, and discipline reviews. I was also responsible for the monitoring and follow-up of all Plans of Correction. As the Chairperson of the Quality

Assurance Committee, I was responsible for the coordination of internal facility reviews, which were based on current ICF/MR and ACDD standards. Other duties included the direction and supervision of Discipline Coordinators for Psychology, Social Services, Speech and Hearing, Cognitive Development, Recreation, Staff Development/Program Evaluation and the Client Records Department. Facility training activities were designed, conducted, evaluated, and documented in a manner that met ICF/MR, ACDD, and DPW requirements. During this period I served as the lead manager in Laurelton Center's effort to achieve accreditation from ACDD. ACDD accreditation was achieved in 1989.

I was also responsible for managing our Regional Resource Program, which provided services to the 11 counties in our catchment area. While these services included the full range of discipline specialties, the majority of requests were due to severe behavior and/or emotional problems. In addition to managing the overall program, I served as the primary behavioral consultant on these issues. During this period I also evaluated services at other state facilities and conducted at least 20 facility reviews. I served as a consultant on ACDD standards and behavior management programs to other facilities throughout Pennsylvania.

October 1976 - May 1983:
Chief of Psychological Services; Selinsgrove State School and Hospital; Selinsgrove, PA

During this period, I was responsible for organizing and coordinating Psychological Services at Selinsgrove State School and Hospital. The position involved the development of department policies and procedures and the training of all Psychological Services staff. I was also involved in institution-wide program evaluations with respect to ICF/MR licensing and ACMRDD accreditation standards. Duties included coordination of the Psychological Services staff through individual and group meetings in an effort to gain consistency in institutional policies and behavior management practices and to provide adequate training for Psychological Services staff. Also included was the direction of the Intensive Treatment Team, a group of four staff members assigned to conduct behavior management programs that required one-to-one coverage for adequate implementation. During this period, I also developed and served as the psychologist for the Social Skills Center, an area that was designed for clients with dual diagnoses with severe behavioral and emotional disturbances. I was responsible for the State of Pennsylvania's first Behavior Management Policy and conducted trainings and consultations on the policy statewide.

September 1973 - July 1974:
House Parent; Wiley House -Residential Care for Emotionally Disturbed Children, Bethlehem, Pa.

I was a house parent in a cottage that provided temporary living arrangements for emotionally disturbed children and adolescents. Activities included basic care, counseling, crises management, educational, recreational and social support. Wiley House provided a variety of living options including residential, respite, foster care and family support. It also provided a full educational program. I worked the afternoon shift as a House Parent so that I could attend graduate psychology classes.

August 1972 - September 1973:
Counselor; Kensington Rehabilitation Center, Philadelphia, Pa.

In this position I served as a mental health and substance abuse therapist/counselor for adolescents and adults with severe addictive disorders... Duties included conducting daily group therapy sessions, vocational training and counseling and individual supportive therapy. The majority of individuals were placed in the facility by the penal system as part of their probation or parole requirement. Other individuals were placed by their families when living in their natural homes became too stressful for the family.

SPECIAL PROJECTS

June 2007- Present US Department of Justice, Civil Rights Division, Washington, D.C.

I serve as a consultant and expert witness for DOJ in their evaluation of the Georgia and Oregon Psychiatric Hospitals implementation of the Olmstead Order regarding admission, care, transition and discharge from psychiatric hospitals.

January 2007 – March 2008 Bazelon Center, Washington, D.C.

I served as a consultant and expert witness for the Bazelon center on an investigation of admission, care and discharge planning for individuals with mental and psychiatric disabilities who live in Nursing homes in San Francisco, California.

June 2004 – July 2007 Human Systems and Outcomes, Tallahassee, Fl.

I served as a consultant on the review and development of the State of Indiana Adult and Children's system of care. I performed reviews of community behavioral health services in numerous counties throughout the state.

May 2002- May 2007 Human Systems and Outcomes, Tallahassee, Fl.

I served as an expert in the review of community behavioral health services provided by the District of Columbia Mental Health System and St. Elizabeth's Hospital. In this role I examined cases and developed reports for the Defendant and Court Monitor.

March 2002 - April 2002 Department of Justice: Verlin Deerinwater, Washington, D.C.

I served as an expert for the United states Department of Justice at the Hawaii Community Mental Health Summit. The Community Summit was held in March 2002. Membership included three representatives appointed by the State of Hawaii; three representatives appointed by the United States Department of Justice; a representative appointed by the Court; and a facilitator and recorder appointed by the Court. Our purpose, as defined by the Court was to, "address the provision of adequate and appropriate mental health services to individuals who have been diverted, transferred and or discharged from Hawaii State Hospital, and propose a plan to implement a system for the delivery of community-based mental health services that address the clinical and social needs, meaning social services including housing, vocational and case management, of individuals who have been or currently are patients or residents of Hawaii State Hospital."

December 2001-January 2004 Department of Justice: Aileen Bell, Washington, D.C.

I served as an expert consultant in a review of the Laguna Honda Hospital in San Francisco, which is a facility that provides skilled nursing services to individuals with disabilities. The issue under review was the facilities compliance with the federal Olmstead Decision.

November 2001 Gains Center: Hank Steadman, Ph.D., Delmar, New York

I provided technical assistance for the Gains Center at an orientation program for Federal SAMHSA grant recipients for grants designed to increase service capacity in the areas of jail diversion and co-occurring disorders.

August 2001 Rand Corporation, Santa Monica, California

I served as an expert consultant for the Rand Corporation as they were researching best practices in the area of treatment for individuals with co-occurring mental health and substance abuse disorders.

April 2000-December 2001: Linda O'Neal, Ph.D.; USA vs. State of Tennessee

I served as a member of an interdisciplinary panel of experts that were assembled to review the compliance of the Arlington Developmental Center with the stipulations of a remedial order. During this review my focus was psychology, habilitation, behavior management, and restraint/seclusion practices.

January 1998-1999 Florida Department of Children and Family Services Expert Panel, Human Systems and Outcomes, Inc., Tallahassee, FL.

I served as a member of a six person expert panel that was constructed to review the Florida Department of Children and Families developmental disabilities service individualized planning process. The panel reviewed a sample of cases and interviewed staff from all levels of the organization. The panel presented findings regarding the current status of the process and made recommendations for improvement.

June 1994-July 1999: Independent Evaluator; Halderman, et al. v. Pennhurst State School and Hospital, Philadelphia, Pa.

In this case I organized and managed the activities of independent evaluators who were assigned to review the records of 550 class members. The evaluation focused on the status of the medical records and the use of anti-seizure and psychotropic medications. The evaluators were general practice physicians, psychologists, neurologists and psychiatrists. I authored reports based on the evaluation results and served as an expert witness in the evaluation of behavioral health services to class members of the Romeo Lawsuit.

May 1992-June 1994: Office of the Monitor; Johnson v. Bradley, Tallahassee, FL.

My role in this case was to provide evaluations of Service Plans that were then used to determine the reliability of the G. Pierce Wood Internal Quality Assurance Audit Process. An instrument was developed by the Office of the Monitor and was utilized to determine compliance with the Court Order. My evaluations were compared with those conducted by the facility staff in order to determine inter-rater reliability.

February 1994- March 1994: Expert Witness: Felix v. Waihee; Honolulu, Hawaii

In this case I served as part of a team of expert witnesses for the evaluation of the community services received by children and youth throughout the state of Hawaii. The individuals lived in a variety of settings from family homes to the Youth Detention Center. The purpose of the evaluation was to determine if the children were receiving adequate educational, developmental disabilities and mental health services. I also participated in the development of the final report for the plaintiffs that included recommendations for the improvement of services for the individuals and the system at large.

June 1992 - August 1994: Office of the Monitor; Superior Court of Arizona; Phoenix, AZ

On this project, I worked for the court appointed monitor and served as an evaluator of the community mental health services provided by the Arizona Department of Health, Division of Behavioral Health which were subject to review based on the Arnold vs. Sarn court decision. An instrument that was developed by the Office of the Monitor was utilized to determine compliance with the Court Order. The evaluation included recommendations for the improvement of services for the class members.

January 1990 - April 1990: New Mexico Protection and Advocacy System; Albuquerque, NM

I served as a consultant in the areas of ICF/MR regulations, ACDD standards, interdisciplinary process, and behavior management. I participated in the review of two state facilities and served as the expert witness in the Jackson v. Fort Stanton and Los Lunas State School and Hospital case.

August 1989 - November 1991: Advocacy Center; Tallahassee, FL

I served as a member of a review team developed to examine services in the Florida mental health system. In this role, my specialty was behavior management techniques and interdisciplinary team process in the use of psychotropic medications. The reviews include a comprehensive examination of program planning, implementation, empowerment, individual rights, and health care.

January 1988 - July 1994: Therapeutic Resources (self-employed); Woodward, PA

This is a position with a private firm that provided the following services to community and institutional programs: behavior management, quality assurance, staff training, vocational, speech, hearing, recreation, cognitive development, assessment, and referral. In this role, I provided behavior management services to

several families, group homes and community facilities. I was also involved in staff training in which I provided in-service training on behavior management, quality assurance, relaxation techniques, developmental programming, and the treatment of individuals with dual diagnoses. I also participated in evaluations in the following cases: Connecticut Traumatic Brain Injury Association, Inc. v. Michael Hogan, et al. and specialized evaluations in individual legal cases.

October 1987 - July 1991: Office of the Special Master; Willowbrook; New York, NY

In this position, I served as part of an audit team that was developed to review New York facilities that are subject to the NYS ARC v. Cuomo class action suit and the subsequent Willowbrook Consent Decree. The audit focused on habilitation, behavior management, the environment, assessment, team process, staff training, and other issues. I had the opportunity to audit several New York facilities over the years. My specialty during these audits was behavior management techniques and psychological services. I have also served as a consultant to the Special Master's Office in the areas of quality assurance, ICF/MR regulations, and vocational services and have generated recommendations for the correction of various problems found at facilities.

September 1987 - January 1993: Therapeutic Concepts, Inc., Winter Park, FL

In this position, I served as a consultant to Therapeutic Concepts, an organization providing managerial and programmatic assistance to Hissom Memorial Center in Oklahoma and other facilities throughout the country. My specific role was that of an evaluator in an ongoing review of client habilitation. Duties included the review of the habilitation plan development and implementation. While employed by Therapeutic Concepts, I also served as an evaluator in the following cases: Homeward Bound v. Hissom Memorial Center, Jackson v. Los Lunas and Fort Stanton, and Bogard et al. v. Illinois.

August 1986: L. R. O'Neal Associates, Tallahassee, FL

In this position, I was involved in the review of facilities in the state of Texas as part of the Lelsz v. Kavanaugh class action suit. Review procedures consisted of a highly structured audit of active treatment programs, program documentation, the interdisciplinary process, and the environment. The results of the reviews have been utilized as ongoing data in the resolution of a suit filed in the United States District Court.

ACADEMIC EMPLOYMENT

2006- Present Arizona State University

Serve as an adjunct faculty member supervising doctoral and pre-doctoral psychology internships.

1979 - 82: Susquehanna University, Selinsgrove, PA

At Susquehanna, I taught courses in Developmental Psychology, Developmental Disabilities, Behavior Therapy, History and Systems of Psychology, and Introduction to Psychology.

1975 - 1976: Saint Louis University, Saint Louis, MO

As a graduate fellow, I taught sections of Physiological Psychology and Learning Theory to graduate and undergraduate students.

1976 - 1977: Parks College of Saint Louis University, Cahokia, IL

I taught General Psychology to undergraduate students.

PROFESSIONAL LICENSE

Licensed Psychologist - PS-002960-L

By the Pennsylvania Commission of Professional and Occupational Affairs

PRESENTATIONS AND PAPERS

1973 An examination of Predictions Concerning the Recall of Verbal Isolates
Eastern Psychological Association Convention, Washington, DC

1974 The Behavior Modification Training Manual
Copyright Pennhurst Center, Spring City, PA

1974 Autoshaping as a Function of the Similarity to the Consummatory Response
Psychonomic Society, Denver, CO

1976 Behavioral Interactions in Fixed-trial Response Independent Reinforcement Procedures
Midwest Association for Behavior Analysis, Chicago, IL

1976 An Application of DRO Procedures with the Profoundly Retarded Adults
Midwest Association for Behavior Analysis, Chicago, IL

1977 Program Organization within a Unitized System
American Association of Mental Deficiency, Baltimore, MD

1978 The "Relativity of Reinforcement" Principle
Gatlinburg Conference, Gatlinburg, TN

1978 A Variation of Required Relaxation for Use with Severe Disruptive Behavior
Eastern Psychological Association, Washington, DC

1978 Program Organization and Accountability within a Large Residential Institution
Pennsylvania Psychological Association Convention, Lancaster, PA

1978 Symposium on Behavioral Procedures
Pennsylvania Association for Research in Mental Retardation, Selinsgrove, PA

1978 An application of Premack's "Relativity of Reinforcement" Principle in the Reduction of Inappropriate Behaviors. American Association of Mental Deficiency, Rehoboth Beach, DE

1979 A Comparison of Maladaptive Behaviors in Seizure and Nonseizure Clients
Gatlinburg Conference, Gatlinburg, TN

1979 An Examination of the Additivity Theory of Behavior Contrast
Eastern Psychological Association, New York, NY

1980 Effects of the Number of Clients per Living Unit on the Rate of Aggressive/Destructive Behaviors, Gatlinburg Conference, Gatlinburg, TN

1980 Institutional Ecology and its Effects on the Mentally Disabled
Pennsylvania Chapter, American Association of Mental Deficiency, State College, PA

1982 Prescriptive Behavioral Assessment: An Alternative to Restrictive Procedure Hierarchies,
Region IX AAMD Conference, Williamsburg, VA

1983 A Mechanism to Increase the Density of Reinforcement in Institutional Settings
Region IX AAMD Conference, Williamsburg, VA

1984 Effects of a Response-Active Environment
PA Chapter AAMD Conference, Hidden Valley, PA

1984 Autoshaping Attending Behavior
Region IX AAMD Conference, Williamsburg, VA

1984 An Interdisciplinary Crisis Assessment Procedure Designed to Reduce Restraint/Exclusion Usage, AAMD Conference, Scranton, PA

1985 Comparative Effects of PUSH Modular Play Units and Traditional Strategies
National AAMD Conference, Philadelphia, PA

1985 Behavior Management and Training of Persons with Severe and Profound Mental Retardation, National AAMD Conference, Philadelphia, PA

1985 A Binary Token System, PA Chapter of AAMD Conference, Harrisburg, PA

1986 Psychopharmacology and Behavior Management, Hamburg Center, Reading, PA

1986 Pennsylvania Office of Mental Retardation Behavior Management Policy

1986 The Behavior Management Policy Video
Pennsylvania Office of Mental Retardation

1988 Pennsylvania Office of Mental Retardation Behavior Management Policy - Update

1990 A Holistic Approach to Physical and Mental Wellness
Community Positive Approaches Conference, Harrisburg, PA

1991 Conducting an Environmental/Functional Analysis
Facility Positive Approaches Conference, Carlisle, PA

1992 Issues in the Thomas S. Lawsuit
North Carolina Association for Behavior Analysis Conference, Greensboro, NC

1994 A Method to Analyze Injuries Caused by Inadequate or Inappropriate Treatment
National Association of Protection and Advocacy Systems, Washington, DC

1995 Quality Assurance in Community Services
North Carolina Community Services Providers Conference, Raleigh, NC

1995 Treatment strategies for the Dually Diagnosed
North Carolina Community Services Providers Conference, Raleigh, NC

1996 The History of Managed Behavioral Health Care
Pennsylvania Association for Supported Employment, Harrisburg, PA

1996 Case Management and Vocational Services
Pennsylvania Association for Supported Employment, Harrisburg, PA

1996 The Incentives of Managed Behavioral Health Care
University of Arizona, Phoenix, AZ

1997 Models of Case Management in Managed Care
University of Tennessee, Chattanooga, TN

1997 The Challenge for Vocational Services in Managed Behavioral Health Care
University of Tennessee, Chattanooga, TN

1998 The Role of Employment in Recovery
Value Options Recovery Conference, Phoenix, AZ

1998 Advances in Integrated Treatment
Arizona Mental Association Conference, Phoenix, AZ

1999 Developing Community Consensus on Best Practice Models
Philadelphia Coordinated Health Care, Philadelphia, PA

1999 Integrated Mental Health and Substance Abuse Treatment
Arizona Rural Health Conference, Honda, AZ

1999 Advances in the Treatment for Co-occurring Disorders
Arizona Mental Health Providers Association

1999 Principles of Integrated Treatment
Arizona Mental Health Association Conference, Phoenix, AZ

2000 Models for Building Community Consensus for the Implementation of "Best Practices".
Gains Center Conference, Miami, Florida

2000 Consensus Models in Building Jail Diversion and Integrated Treatment
Innovations in Forensic Mental Health, New York University, New York, NY

2000 Systems Change to Improve Treatment Models for Co-Occurring Disorders
State Mental Health Program Directors Meeting, Minneapolis, Minnesota

2000 Integrated Mental Health and Substance Abuse Services.
Arizona Substance Abuse Consortium, Prescott, AZ

2000 Creating Jail Diversion Programs, American Society of Criminology Conference, San Francisco

2000 Collaboration between Crisis Services and Jail Diversion, NASMPD Forensic Division, AZ.

2001 Treatment Guidelines for Co-Occurring Disorders, Arizona Substance Abuse Research Consortium, Honda, AZ.

2001 Arizona Initiative to Improve Services to Individuals involved in the Criminal Justice System.
Arizona Mental Health Association Conference, Prescott, AZ.

2001 Supportive Housing for Individuals with Serious Mental Illness and Substance Abuse Disorders, Housing for the Homeless Conference, Phoenix, AZ.

2001 Crisis Intervention Training for the Phoenix Police Department, Phoenix, AZ.

2001 Integrated Treatment for Co-Occurring Disorders in a Rural Setting, National Rural Mental Health Association Conference, Wilmington, N.C.

2002 Best-Practice Guidelines for the Treatment of Co-Occurring Disorders, American Association of Community Psychiatrists Conference, Tucson, AZ.

2002 Court Ordered Treatment, Health Ed Resources, Phoenix, AZ.

2002 Arizona HIPAA Compliance, CMHS, AZ.

2002 Behavioral Health Services in Rural Communities, Arizona Rural Health Association, Prescott, AZ.

2002 Arizona Jail Diversion Programs, Innovations in Forensic Mental Health, New York University, New York, NY.

2002 Evaluation in the Real World, Arizona Substance Abuse Research Consortium, Sedona, AZ..

2002 A comparison of Supported and Independent Housing Programs, Housing for the Homeless Conference, Phoenix, AZ.

2002 Evaluating Behavioral Health Programs, National Conference of State Legislatures, AZ.

2002 Update on Arizona Behavioral Health Services, Mental Health Association Conference, AZ.

2003 Using a Logic Model to Determine Behavioral Health Network Sufficiency, DC.

2003 Developing an Integrated Mental Health and Substance Abuse Assessment, AZ.

2003 Benefits of Mental Health Courts, AZ.

2003 Evidence-Based Management of Schizophrenia, AZ.

2003 Justice Re-entry Strategies to Prevent Homelessness, AZ.

2004 Advancement in the treatment of Co-Occurring Disorders, National Institute on Drug Abuse Meeting, AZ.

2004 The Arizona Implementation of the New Freedom Commissions Report, Consumer Education Coalition, Tucson, AZ.

2004 Supported Housing: A Recovery Oriented and Cost-effective Alternative to Institutionalization. Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics, Washington, DC.

2004 Building a Recovery Oriented Behavioral Health System. Substance Abuse Summer Institute, University of Arizona.

2005 Developing Peer and Family Support in Arizona. Recovery Conference, Phoenix, Arizona.

2005 A Logic Model for analyzing Network Sufficiency, Summer Institute, Sedona, Arizona.

2005 Panel Discussion on Criminal Justice and Mental Illness, Phoenix, Arizona.

2005 Transforming Mental Health Systems into Recovery-Oriented Systems. Olmstead Coordinators Meeting. Washington, DC.

2005 Evidence-Based Practices and Recovery are Synergistic. Phoenix, Arizona.

2006 Got No-Shows. We have a Solution. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2006 Reducing No-Shows using a Client Directed Outcome Informed Approach. Southwest Training Institute. Tucson, Arizona.

2006 An analysis of Retention and Treatment Outcomes from Peer Support Services using the Client Directed Outcome Informed Treatment Approach. National State of the Knowledge Conference on Increasing Community Integration of Individuals with Psychiatric Disabilities. University of Pennsylvania Health System. Philadelphia, Pa.

2006 The Village Program: An Integrated Service Model. Statewide Conference on Homelessness, Arizona Coalition to End Homelessness. Phoenix, Arizona.

2006 Client Directed Outcome Informed Treatment. Statewide Conference on Homelessness, Arizona Coalition to End Homelessness. Phoenix, Arizona.

2006 A Behavioral, Phenomenological and Motivational Analysis of Why People Change and Why They Don't. Training Institute Lecture Series. Argosy University. Phoenix, Arizona.

2006 This Treatment isn't working. Could it be me? Mental Health Association Annual Conference. Phoenix, Arizona.

2006 Village approach to service delivery. Behavioral Health Community Forum. Phoenix, Arizona.

2007 Employment recovery services for people with behavioral health challenges. CARF Employment and Community Services International Conference. Tucson, Arizona..

2007 Client Directed Outcome Informed Treatment. United States Psychiatric Rehabilitation Association Annual Conference. Orlando, Florida.

2007 Adolescent Co-occurring Disorders and Effective Treatment Option. Family Centered Practice Conference. Phoenix, Arizona.

2007 Introduction to the Client Directed Outcome Informed Clinical Approach. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2007 Supervision of the Client Directed Outcome Informed Approach/Motivational Interviewing. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2007 Introduction to the Client Directed Outcome Informed Clinical Approach. Southwest Training Institute. Tucson, Arizona.

2007 Supervision of the Client Directed Outcome Informed Approach/Motivational Interviewing. Southwest Training Institute. Tucson, Arizona.

2007 State and national Issues in Behavioral Health Services. Eric Gilbertson Advocacy Training Institute for Behavioral Health. Phoenix, Arizona.

2007 Use of Recovery Relationships: Demonstrating Effectiveness of Peer Supports. Arizona Coalition to End Homelessness. Phoenix, Arizona.

2008 Innovative Job Modifications for People with Long Term Mental Health Challenges in Recovery. CARF International Conference. Tucson, Arizona.

2008 A Person Centered Treatment Planning approach. Eric Gilbertson Advocacy Training Institute for Behavioral Health. Phoenix, Arizona.

2008 Cultural Competency: A Practical Method for Clinicians. 6th Annual Indian Health Services Conference on Behavioral Health/ Maternal Health. Phoenix, Arizona

2008 Benefits of the Child and Family Team Approach. 12th Annual Family Centered Practice Conference. Phoenix, Arizona.

2008 Translating What Works: Peer Support and Recovery. Heart and Soul of Change Conference. Phoenix, Arizona.

2008 Achieving Excellence in Supervision. Heart and Soul of Change Conference. Phoenix,, Arizona.

2008 Achieving Excellence in Your Setting. Heart and Soul of Change Conference. Phoenix, Arizona.

2008 Housing Services and Supports. Arizona Housing Summit. Phoenix, Arizona.

2008 Peer Support and Outcome-Informed Practices. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

CHAPTERS AND JOURNAL ARTICLES

2009 Transforming Public Behavioral Health Care: A Case Example of Consumer Directed Services, Recovery and Common Factors. With Robert Bohanske. In The Heart and Soul of Change, 2nd Edition: Delivering What Works in Therapy. Duncan, B., Miller, S., Wampold, B. and Hubble, M. American Psychological Association Press.

2008 Wellness and Recovery Employment Standards. With Randy Gray. Job Training and Placement Report. Volume 32, 9 , 1-3.

2007 Introduction to Child and Family Teams. With Bob Bohanske. Distributed by the Maricopa County Consumers, Advocacy and Providers Association.

2006 Arizona Behavioral Health Supervisory Training Series. With Bob Bohanske. Distributed by the Arizona Behavioral Health Providers Association.

2005 Housing Choice, Outcomes, and Neighborhood Characteristics in Seriously Mentally Ill/ Homeless Housing Programs: Analysis of a Phoenix Survey of SMI / Homeless Population with Alvin Mushkatel, Subhrajit Guhathakurta, and Jacqueline D. Thompson in International Journal of Public Administration

2004 An Analysis of Post-Booking Jail Diversion Programming for Persons with Co-Occurring Disorders. In **Behavioral Science and the Law** 22: 771-785. With Michael Shafer and Brian Arthur.

2002 Mental Illness and Substance Abuse: Making Matters Worse. In M. Berren (Ed.). **A Sourcebook for Families Coping with Mental Illness**. (pp 95-106), Mc Murray Publishing. With Christina Dye.

2001 Treating Offenders with Mental Disorders ad Co-Occurring Substance Abuse Disorders. In G. Landsberg and A, Smiley (Eds.) **Forensic Mental Health: Working with the Mentally Ill Offender**. Chapter 10 pp 1-21. With Christina Dye. Civic Research Institute.

2001 Jail Diversion in a Managed Care Environment: The Arizona Experience. In G. Landsberg and A, Smiley (Eds.). **Serving Mentally Ill Offenders** Chapter 8 pp 107-119. With Mike Shafer. Springer Publishing.

2001 Knowledge Transfer: Policymaking and Community Empowerment: **A Consensus Model Approach for Providing Public Mental Health and Substance Abuse Services**. With N. Broner, Christina Dye and William McAllister. Psychiatric Quarterly, Vol. 72 pp 79-102.

2001 Arizona's Integrated Treatment Initiative for the Dually Diagnosed. In **Community Mental Health Report**. Vol. 1 pp 21-27. Civic Research Institute. With Christina Dye.

2000 Collaboration: The Key to Successful Jail Diversion. **Proceedings from the Crime and Criminology in the Year 2000 Conference**. American Society of Criminology.

AWARDS

1990 Pennsylvania Department of Welfare Services Award

1997 Arizona Governor's Excellence Award for the development of a computerized Case File Review Tool.

1997 Arizona Governor's Excellence Award for the development and implementation of a Problem Resolution System.

2000 Arizona Governor's Excellence Award for initiating the Arizona Integrated Treatment Consensus Panel.

FEDERAL GRANT AWARDS

1995 Principal Investigator - Consumer Support Program - Funded by Substance Abuse Mental Health Services Administration.

1997 Principal Investigator - Housing Approached for Persons with a Serious Mental Illness - Funded by Substance Abuse Mental Health Service Administration.

1997 Principal Investigator - Jail Diversion for Persons with a Serious Mental Illness - Funded by Substance Abuse Mental Health Service Administration

1998 Co-Principal Investigator - Exemplary Practices Initiative - Integrated Substance Abuse Mental Health Treatment Models. - Funded by Substance Abuse Mental Health Service Administration.

1998 Principle Investigator - PATH Grant for Homeless Outreach - Funded by Substance Abuse Mental Health Services Administration.

2000 Principal Investigator – Project MATCH- Children's System of Care Initiative - Funded by Substance Abuse Mental Health Services Administration.

2001 Co-Principal Investigator – System Expansion Initiative for Treatment for Individuals with Co-Occurring Disorders- Funded by Substance Abuse Mental Health Services Administration.

2001 Project Coordinator – Olmstead Plan - National and State-Wide Coalition to Promote Community-Based Care.

2002 Co-Principle Investigator – Data Infrastructure Grant - Funded by Substance Abuse Mental Health Services Administration.

2004 Principle Investigator- State Infrastructure Grant for Children's Services – Funded by the Substance Abuse Mental Health Services Administration.

2005 Principle Investigator – Substance Abuse Services for Adolescents and Young Adults – Funded by the Substance Abuse Mental Health Services Administration.

2009 Project Director – Arizona project to assist individual's transition from Homeless to Independent Housing with Behavioral Health Services. – Funded by the Substance Abuse Mental Health Services Administration.

Exhibit B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

MICHELE HADDAD,

Plaintiff,

vs. Case No. 3:10-cv-414-J-99MMH-TEM

THOMAS ARNOLD, in his official capacity as Secretary, Florida Agency for Health Care Administration, and

DR. ANNA VIAMONTE ROSS, in her official capacity as Secretary, Florida Department of Health,

Defendants.

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OPINION

THIS CAUSE came before the Court on Plaintiff Michele Haddad's[1] Motion for Preliminary Injunction, Memorandum in Support Thereof, and Expedited Hearing (Doc. No. 2; Motion),[2] filed on May 13, 2010. Plaintiff is suing Defendants, under 42 U.S.C. § 12133 and 29 U.S.C. § 794(a), alleging that they are discriminating against her on the basis of her disability in violation of the Americans with Disabilities Act (the "ADA") and the Rehabilitation

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1 Plaintiff is also involved in the related case of Jones v. Arnold, 3:09-cv-1170-J-34JRK, as a member of a putative class sought to be certified. See May 7, 2010 Order (3:09-cv-1170-J-34JRK Doc. No. 62) at 1. She initially filed a motion for preliminary injunction in the Jones case, but the Court denied that motion without prejudice because, as an unnamed class member in an uncertified class, Plaintiff was not yet a party to the action and lacked standing to seek preliminary injunctive relief therein. See id. at 1-3. Subsequently, Plaintiff filed the present action and the instant motion in her own name.

2 Attached to the Motion are Plaintiff Michele Haddad's Declaration in Support of her Motion for a Preliminary Injunction (Doc. No. 2-1; Haddad Dec.), the Declaration of Jeffery S. Johns, M.D. (Doc. No. 2-2; Johns Dec.), and the Affidavit of Kristen Russell (Doc. No. 2-3; Russell Aff. I), which was originally filed in the related Jones case.

Act (the "Rehab Act"). See Complaint (Doc. No. 1) at 1, 11-13. In the Motion, Plaintiff requested that the Court enjoin Defendants from denying her Medicaid in-home services in order to prevent her from being forced into unnecessary institutionalization in a nursing home. See Motion at 1.

I. PROCEDURAL HISTORY

Upon review of the Motion, the Court entered an order taking the Motion under advisement and directing Plaintiff to serve the Motion and supporting materials on Defendants. See May 13, 2010 Order (Doc. No. 4) at 1. While Plaintiff was complying with the Court's order, the United States filed a motion seeking leave to submit a brief in this action, see United States' Motion for Leave to Appear Specially (Doc. No. 6) at 1, and the Court granted that request, see May 21, 2010 Order at 1-2. As such, the United States filed its brief on May 24, 2010.[3] See Statement of Interest of the United States of America (Doc. No. 10; Statement of Interest).

Once Plaintiff accomplished service of process,[4] the Court entered another order scheduling a hearing on the Motion for June 7, 2010, and set an expedited briefing schedule due to the urgency of this matter. See May 25, 2010 Order (Doc. No. 13) at 1-2. In the May

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[3] Attached to the Statement of Interest are the following: an additional copy of the Russell Affidavit I (Doc. No. 10-1 at 5); a letter dated February 23, 2010 (Doc. No. 10-1 at 7-9; February 23, 2010 Letter); Defendants' Response and Memorandum of Law in Opposition to Michele Haddad's Motion for Preliminary Injunction (Doc. No. 10-1 at 11-29), originally filed in the Jones case; Initial Brief from Holly Benson, in her Official Capacity as Secretary, Florida Agency for Health Care Administration, and Douglas Beach, in his Official Capacity as Secretary, Florida Department of Elder Affairs (Doc. No. 10-1 at 31-88; Benson Brief), from the Eleventh Circuit Court of Appeals action, Benson v. Long, Case No.: 08-16261AA; January 25, 2010 Memorandum and Order Doc. No. 38 (Doc. No. 10-1 at 90-98; Benjamin Order), from the United States District Court for the Middle District of Pennsylvania action, Benjamin v. Dep't of Pub. Welfare, Commonwealth of Pa., 09-cv-1182; and a copy of Olmstead v. L.C. ex rel Zimring, 527 U.S. 581 (1999).

[4] See Returns of Service (Doc. Nos. 11 and 12) filed May 25, 2010.

25, 2010 Order, the Court directed Defendants to respond to the Motion by May 28, 2010, and permitted Plaintiff to submit a reply brief on or before June 2, 2010. See id. at 2-3. However, on May 27, 2010, Defendants filed an emergency motion requesting an extension of time in which to file their response. See Emergency Motion for Extension of Time (Doc. No 20; Emergency Motion) at 1-2. That same day, the Court held a telephonic hearing on the Emergency Motion. See May 27, 2010 Order (Doc. No. 21) at 1. During the hearing, Plaintiff's counsel advised that Plaintiff was, at that time, hospitalized due to medical complications unrelated to the alleged denial of services that are the subject of this action. Although counsel did not know when she would be medically able to be discharged, he indicated that Plaintiff was in limbo and would be unable to go home without the provision of the services at issue in the instant litigation. After hearing from the parties, the Court granted Defendants' requested extension and continued the hearing on the Motion until June 15, 2010. See Clerk's Minutes (Doc. No. 22) at 1. However, in light of Plaintiff's circumstances, the Court directed Plaintiff's counsel to immediately file a notice if Plaintiff was medically able to be released from the hospital, but not able to do so because of the unavailability of in-home health care services. In accordance with the Court's directives from the May 27, 2010 hearing, the parties timely filed their responsive memoranda, see Defendants' Response and Memorandum of Law in Opposition to Plaintiff's Motion for Preliminary Injunction (Doc. No. 27; Response); Plaintiff Michele Haddad's Response to

Defendants' Memorandum in Opposition to the Preliminary Injunction (Doc. No. 29; Reply), which are supported by various documents.[5]

The Court held a hearing on the Motion on June 15, 2010. See Clerk's Minutes (Doc. No. 39; Preliminary Injunction Hearing). At the beginning of the hearing, Plaintiff's counsel advised that Plaintiff's medical condition was improving. Indeed, Plaintiff was able to leave the hospital for a period of time to attend a portion of the hearing in person. Her counsel also advised the Court that he had spoken to Plaintiff's social worker who indicated that Plaintiff was expected to be discharged from the hospital in two to three weeks. At the conclusion of the hearing, after again confirming that Plaintiff was expected to remain hospitalized for reasons unrelated to the allegations in this action for an additional period of two to three weeks, the Court requested additional briefing from the parties on one legal issue. The parties have filed those memoranda. See Plaintiff Michele Haddad's

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[5] The Response is supported by the following: the Affidavit of Elizabeth Y. Kidder in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 24-1; Kidder Aff.); a draft copy of the Florida Nursing Home Transition Plan (Doc. No. 24-2; Transition Plan); a copy of the Settlement Agreement from Long v. Benson, 4:08cv26-RH/WCS in the United States District Court for the Northern District of Florida (Doc. No. 24-3; Long Settlement); the Affidavit of Kristen Russell in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 25-1; Russell Aff. II); the Affidavit of Susan Michele Hudson in Support of Defendant's [sic] Response and Memorandum of Law in Opposition to Motion for Preliminary Injunction (Doc. No. 26-1; Hudson Aff.); and another copy of the Russell Affidavit I (Doc. No. 27-1).

The Reply is accompanied by copies of the following: SSI-Related Programs Fact Sheets January 2010 (Doc. No. 29-1; Fact Sheets); Appendix C-Eligibility and Post-Eligibility Medicaid Eligibility Groups Served (Doc. No. 29-2; Medicaid Eligibility); Appendix B-4: Medicaid Eligibility Groups Served in the Waiver (Doc. No. 29-3; Waiver Eligibility); AARP Across the States Profiles of Long-Term Care and Independent Living (Doc. No. 29-4; AARP Profile); Florida Medicaid Nursing Homes January, 2010 Rate Semester Initial Per Diems (Doc. No. 29-5; Per Diem); a series of documents related to Defendants' October 2007 amendment of Florida's Home- and Community-Based Waiver for Individuals (aged 18 and older) with Traumatic Brain or Spinal Cord Injuries (Doc. No. 29-6; Waiver Amendment); Home and Community Based Service Waivers and Long Term Care (Doc. No. 29-7; Waiver List); Kaiser Commission on Medicaid and the Uninsured November 2009 (Doc. No. 29-8; Kaiser Report); Spinal Cord Injury in Florida, a Needs and Resources Assessment (Doc. No. 29-9; Assessment); and a letter dated January 8, 2010 (Doc. No. 29-10; January 8, 2010 Letter).

Memorandum in Response to the Court's Request Regarding Preliminary Injunction Standards (Doc. No. 41; Plaintiff's Memorandum); Defendants' Memorandum of Law on the Standard for Injunctive Relief (Doc. No. 43-1; Defendants' Memorandum); United States' Memorandum of Law Regarding the Preliminary Injunction Standard (Doc. No. 44; United States' Memorandum).

In addition to filing Plaintiff's Memorandum as directed on June 21, 2010, Plaintiff's counsel filed a notice indicating that he had "just received notice that Brooks Rehabilitation Hospital plans to discharge Michele Haddad on Thursday, June 24, 2010." See Notice of Status Regarding Michele Haddad (Doc. No. 40; Plaintiff's Notice of Status). By the time the Court reviewed Plaintiff's Notice of Status, having had the benefit of the parties' briefing and the arguments presented at the hearing, the Court had determined that preliminary injunctive relief was warranted and was in the process of preparing a written opinion and order which would grant Plaintiff relief and set forth the Court's reasons for doing so. However, upon review of Plaintiff's Notice of Status, the Court determined that the urgency of the circumstances required the issuance of an order resolving the Motion without a delay solely necessary to complete the preparation of a written opinion. Thus, the Court granted the Motion with the intention of providing an opinion setting forth its reasoning at a later date. See June 23, 2010 Order (Doc. No. 46) at 8. The Court fulfills that intention here.

II. FACTUAL BACKGROUND[6]

Plaintiff is a forty-nine-year-old resident of Florida. See Haddad Dec. at 1. On September 7, 2007, when she was forty-seven, Plaintiff was in a motorcycle accident caused by an intoxicated driver. See id. As a result of the accident, Plaintiff is paralyzed from the chest down and has a diagnosis of quadriplegia, with a spinal injury at the c6-c7 vertebrae. See Johns Dec. at 3; see also Haddad Dec. at 2. Plaintiff is mentally alert and fully aware of her surroundings, but she has minimal manual dexterity. See Johns Dec. at 4; see also Haddad Dec. at 3. Her right hand remains closed, and her left hand remains open. See Johns Dec. at 4; Haddad Dec. at 3. However, she has some limited ability to use her arms. See Johns Dec. at 4. After her accident, Plaintiff required a tracheotomy, which has been removed, but Plaintiff cannot speak and breathe at the same time. See id. Additionally, she is required to take various medications, and is at risk for injury and infection due to her catheterization. See id. Plaintiff uses a motorized wheelchair for mobility, and resides in a wheelchair-accessible home with a roll-in shower. See id.; Haddad Dec. at 2-3. Nevertheless, Plaintiff is completely dependent on others to help her perform most of her activities of daily living, including transferring from her bed to her wheelchair, dressing, bathing and showering, toileting, bladder management, assistance with bowel movements, including digital stimulation, and shopping for, preparing, and eating food. See Johns Dec.

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[6] The Court notes that, as the Motion was one for preliminary injunctive relief and necessarily before the Court on an expedited schedule, the factual record contained herein may not be completely developed. Therefore, the following facts and conclusions of law do not necessarily reflect what may be established on a record more fully developed following trial on these issues. Accordingly, the determinations in this Order are expressly limited to the record before the Court at the time of the Preliminary Injunction Hearing and do not indicate or limit the ultimate outcome of the issues presented in this matter.

at 4; see also Haddad Dec. at 3. She requires ten to twelve hours a day of in-home assistance to remain in the community.[7] See Johns Dec. at 5.

Plaintiff's rehabilitation is ongoing, and she uses the out-patient equipment and facilities at Brooks Rehabilitation Hospital ("Brooks") in Jacksonville, Florida, where she was a patient from November 2007 to January 2008, after her accident. See Johns Dec. at 3-4. Despite her dependence on the care from others, Plaintiff has maintained an active life in the community. See Haddad Dec. at 4; see also Johns Dec. at 5. She attends church, goes to the movies, visits friends, goes shopping, and exercises at the Brooks gymnasium. See Haddad Dec. at 4; see also Johns Dec. at 5. At the telephonic hearing on May 27, 2010, Plaintiff's counsel represented that Plaintiff had experienced medical complications requiring another tracheotomy and had been hospitalized at Brooks where she would remain for an unknown length of time. On June 21, 2010, Plaintiff's counsel notified the Court that Plaintiff was scheduled to be discharged from Brooks on June 24, 2010. See Plaintiff's Notice of Status at 1.

After Plaintiff's initial discharge from Brooks in January 2008, her husband was her primary care giver. See Haddad Dec. at 3; see also Johns Dec. at 5. In November 2009, Plaintiff and her husband divorced, yet he continued to provide Plaintiff's care until he moved out of their home in March 2010. See Haddad Dec. at 3; Johns Dec. at 5. After that time, one of Plaintiff's adult sons, who was living in Miami, Florida and had recently graduated

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[7] In the Complaint, which is not verified, Plaintiff asserts that she would require "about seven hours a day for all her activities of daily living." See Complaint at 5. However, Plaintiff's physician's declaration indicates that, in his medical opinion, Plaintiff "requires about 10-12 hours a day of in-home assistance in order to meet her needs." See Johns Dec. at 5. Likewise, in her declaration verifying the Motion, Plaintiff indicates that Defendants offered her 10 hours a day of services in the community if she would move into a nursing home. See Haddad Dec. at 3-4.

from college, temporarily moved back home in order to provide Plaintiff the care she needed to remain in the community. See Haddad Dec. at 3; Johns Dec. at 5. From that time until Plaintiff's hospitalization, her son became responsible for all of the tasks Plaintiff's husband had performed, including very personal care, such as hygiene and administering Plaintiff's bowel program. See Haddad Dec. at 3-4; see also Johns Dec. at 5. Plaintiff's son returned to care for Plaintiff because of her exigent circumstances, but would be unable to provide these services to Plaintiff indefinitely. See Haddad Dec. at 4. Indeed, he intended to return to his responsibilities in Miami. See id.; Johns Dec. at 5. Upon such occurrence, absent other assistance, Plaintiff would be forced to leave the community and enter a nursing home in order to receive the care she requires. See Haddad Dec. at 4-5; Johns Dec. at 5.

Defendants are responsible for administering Florida's in-home services waiver programs, see Kidder Aff. at 1; Hudson Aff. at 1; Russell Aff. II at 1, including the Traumatic Brain Injury/Spinal Cord Injury Waiver ("TBI/SCI Waiver") program implemented in 1999, see Kidder Aff. at 2; Hudson Aff. at 1-3. Through this program, the state delivers in-home services, such as home health care and related services, to Medicaid eligible persons with traumatic brain or spinal cord injuries so that they can remain in the community. See Russell Aff. II at 1-2. The TBI/SCI Waiver program grew from a monthly caseload of 245 persons and yearly expenditures of $5,874,815 in fiscal year 2005 to 2006, to 309 persons and $10,066,381 in 2008 to 2009. See Hudson Aff. at 3. Defendants have various other waiver programs that deliver services to persons with other physical and mental disabilities. See id. at 1-3; Kidder Aff. at 2. These programs have increased in size and scope over the course of their existence. See Hudson Aff. at 1-3. In fiscal year 2008 to 2009, the average

monthly caseload of Medicaid recipients in nursing homes was approximately 50,000, and the average monthly caseload in in-home services waiver programs was approximately 61,000. See id. at 4.

In November 2007, while Plaintiff was still at Brooks, she applied to receive services under Defendants' TBI/SCI Waiver. See Haddad Dec. at 2-3; see also Johns Dec. at 5. However, Plaintiff has not received any TBI/SCI Waiver services despite having been on the waiting list for approximately two-and-a-half years. See Haddad Dec. at 3-5. In a letter dated January 8, 2010, Defendants acknowledged that Plaintiff was on a waiting list to receive in-home services, but explained:

> [p]resently, the Department of Children and Families does not have funds available (or available openings) to serve additional individuals through these programs. . . . Placement on the waiting list does not ensure future eligibility. Funding is very limited in these programs, and the amount of funding allocated to these programs has not been increased in many years. Unfortunately, moving individuals off the waiting list into these programs does not occur frequently, therefore, we encourage you to continue seeking services from other programs.

January 8, 2010 Letter at 1.

Plaintiff's income is limited to her Social Security Disability Insurance, and she is eligible for, and receives, Medicare and Medicaid. See id. at 4. With her other sources of assistance withdrawing, Plaintiff faced the risk of institutionalization without in-home services through Defendants' TBI/SCI Waiver.[8] See id. at 5; Johns Dec. at 5. Accordingly, Plaintiff

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[8] Plaintiff argues that an additional potential source of assistance is Defendants' personal care services waiver, but contends that this program is only available to individuals residing in nursing homes. See Motion at 5-6, 19 n.5; Transcript of June 15, 2010 Hearing (Doc No. 47; Tr.) at 8. However, at the hearing, Defendants argued that there is no personal care services program. See Tr. at 33-35, 100-02. Instead, services of a personal nature, such as those Plaintiff requires, which are rendered to individuals in nursing homes are incidental to the nursing home placement. See id. They are not the (continued...)

contacted Defendants in early March 2010, to notify them of the change in her circumstances, and that she desperately required in-home services. See Haddad Dec. at 4. In late April 2010, Defendants informed Plaintiff that there were no funds for in-home services, but if she would move into a nursing home, after sixty days in the nursing home, she would be eligible to receive ten hours a day of in-home services through the Florida Nursing Home Transition Plan (the "Transition Plan"). See id.; Russell Aff. I at 2; Tr. at 109-15; see also Transition Plan at 1-12; Long Settlement at 1-13. However, Plaintiff does not wish to enter a nursing home; she wishes to receive the in-home services for which she is medically and financially eligible and to remain in the community, where she leads an active life. See Haddad Dec. at 3-4. Additionally, Plaintiff's physician opines that, even if she meets the criteria for nursing home care, Plaintiff will quickly become depressed and her health will most likely deteriorate if she is placed in a nursing home. See Johns Dec. at 5.

Plaintiff is eligible for the TBI/SCI Waiver, see Kidder Aff, at 3; Medicaid Eligibility at 1-2; Waiver Eligibility at 1-2; Fact Sheets at 4-5, and would benefit from the program, see Johns Dec. at 5, however, Defendants have represented that there are no funded slots available in the program at this time, see January 8, 2010 Letter at 1; Russell Aff. I at 2; Haddad Dec. at 4. Priority of placement on the TBI/SCI Waiver waiting list is based on the probability, given the individual's level of community support and severity of needs, that, but for the TBI/SCI Waiver, the non-institutionalized individual will be institutionalized or the

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[8](...continued)
subject of an independent waiver or funding source. See id. Plaintiff focused her argument on the waiver program and provided little argument regarding her entitlement to in-home services based on the fact that such services would otherwise be incidental to institutionalization. As such, the Court's ruling addresses only Plaintiff's primary argument at this time.

institutionalized individual will not be deinstitutionalized. See Russell Aff. II at 2. At the Preliminary Injunction Hearing, defense counsel was unsure of Plaintiff's exact position on the waiting list, but represented to the Court that she was not in the top forty-five spots. See Tr. at 51-52. Defendants did not know the average wait time for individuals on the waiting list or the average turnover. See id. at 54, 57, 102-03. However, Defendants explained that, because movement on the waiting list is based on an individual's needs, rather than time spent on the waiting list, the wait time can vary greatly from person to person. See id. at 102-03. If a person's needs change, they can request reassessment which can change their position on the waiting list. See id. at 102-03, 115. Nevertheless, despite Plaintiff's contact with Defendants in March 2010, advising them of her change in circumstances, Plaintiff has not been reassessed since January 2010. See id. at 115-16.

Although Plaintiff has been on the waiting list for waiver services since at least early 2008, and Defendants have represented to Plaintiff that the TBI/SCI Waiver program is full, the data from 2008 to 2009 may conflict with this representation. The TBI/SCI Waiver has been approved for 375 persons for the period beginning July 1, 2007, through June 30, 2012. See Waiver Amendment at 1. According to the Waiver List, which summarizes information regarding the utilization and cost of the state's various waiver programs, as of November 1, 2008, the TBI/SCI Waiver had an enrollment of only 343 persons and a waiting list of 554 persons. See Waiver List at 2. Additionally, the Hudson Affidavit represents that, at the end of fiscal year 2008 to 2009, enrollment in the TBI/SCI Waiver was 309 persons. See Hudson Aff. at 3. Thus, it is unclear whether all 375 funded slots in the TBI/SCI Waiver Program are fully utilized.

Even if the program is full, Defendants readily acknowledge that they could expand the number of slots in the program before 2012, see id. at 59-60, but that would only guarantee money from the federal government. Defendants would still need to provide Florida's portion of the funding, as well as the expanded provider network necessary to support such an expansion, see id. at 65-66. However, Defendants provided no evidence as to the cost or impact of such an expansion on other programs or its ability to provide adequate services to the state's disabled population. Nevertheless, Defendants do assert that placing Plaintiff into the program would violate the TBI/SCI Waiver rules because Plaintiff is not next on the waiting list, and that if Defendants were forced to place Plaintiff in the TBI/SCI Waiver, they would have to reduce services that others in the program are currently receiving. See Russell Aff. I at 2; see also Tr. at 49-50, 66-67.

Nursing home care is a mandatory service under Medicaid, and if Plaintiff is required to enter a nursing facility, Defendants would have to pay for such care irrespective of budgetary constraints. See Tr. at 111. Defendants admit that, "[i]n most cases, when a Medicaid recipient is diverted or transitioned from a nursing facility to an [in-home services] waiver program, costs to Medicaid for providing care to that individual are reduced." Hudson Aff. at 3. Indeed, for budgeting purposes, Defendants assume a two-to-one savings for those diverted from nursing homes. See id. at 3-4. However, because of Defendants' budget structure, Defendants would require Plaintiff to enter a nursing home, where funding comes from the state's nursing home line item which the state is required to pay. See Tr. at 111. Then, after at least sixty consecutive days in a nursing facility, Plaintiff would be

eligible for the in-home services she requires from the TBI/SCI Waiver through the Transition Plan. See Kidder Aff. at 2; Tr. at 110-14.

The Transition Plan is independently funded by the Florida legislature through the nursing home line item, see Kidder Aff. at 2; Tr. at 112, and was implemented to give Defendants a funding source to deinstitutionalize individuals who are qualified for in-home services but are languishing in nursing homes because of full waiver programs, see Tr. at 110-11. Essentially, the Transition Plan gives Defendants' budget flexibility. See id. at 111. The sixty-day requirement was implemented to avoid gamesmanship, such as individuals entering nursing facilities for a day and then jumping out immediately into a waiver program, see id. at 112-14, and Defendants contend that the requirement assures that an individual would legitimately, but for in-home services, enter a nursing home and be institutionalized, see id. at 104-06 ("Well, if somebody is going to spend 60 days in a nursing home, that makes it much more likely that they would have had to, without these waiver services, go into a nursing home. It's essentially an assessment of need."). Additionally, Defendants explain that the policy reflects Florida's focus on deinstitutionalization as a priority over diversion. See id. at 106-07. Notably, however, Defendants do not assure that Plaintiff will be transitioned into the TBI/SCI Waiver immediately after sixty consecutive days in a nursing facility. See id. at 19, 73-75. Instead, Defendants state that Plaintiff would have to be institutionalized for "at least" sixty days, but then would have to be assessed and be determined to be safe for community placement. By this action, Plaintiff seeks injunctive relief requiring Defendants to provide her with in-home services without first subjecting herself to unnecessary institutionalization.

III. DEFENDANTS' "STANDING" CHALLENGE

As an initial matter, Defendants assert that Plaintiff lacks standing to pursue this action because she has not been discriminated against "by reason of . . . disability" and because any claims she has are precluded by a settlement reached in the case of Dubois v. Levine, Case No. 4:03-CV-107-SPM from the United States District Court for the Northern District of Florida. See Defendants' Motion to Dismiss Complaint (Doc. No. 32; Motion to Dismiss).[9] Although Defendants did not raise these arguments as a challenge to Plaintiff's standing to sue in response to the Motion, they did present them in their Motion to Dismiss and during the Preliminary Injunction Hearing. While Defendants suggest that their arguments present a challenge to Plaintiff's standing to pursue this action, that contention is simply without merit.

Standing is a jurisdictional requirement, and the party invoking federal jurisdiction has the burden of establishing it. See Lujan v. Defenders of Wildlife, 504 U.S. 555, 561 (1992). In order to establish standing under Article III of the United States Constitution, a plaintiff must "allege such a personal stake in the outcome of the controversy as to warrant [her] invocation of federal-court jurisdiction and to justify exercise of the court's remedial powers on [her] behalf." Watts v. Boyd Properties, 758 F. 2d 1482, 1484 (11th Cir. 1985) (quoting Warth v. Seldin, 422 U.S. 490, 499-500 (1975)). Specifically, a plaintiff must prove three elements in order to establish standing: (1) that he or she has suffered an "injury-in-fact," (2) that there is a "causal connection between the asserted injury-in-fact and the challenged

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[9] Plaintiff has responded to the Motion to Dismiss. See Plaintiff Michele Haddad's Memorandum of Law in Opposition to Defendants' Motion to Dismiss Complaint (Doc. No. 35; Response to Motion to Dismiss).

action of the defendant," and (3) that a favorable decision by the court will redress the injury. See Shotz v. Cates, 256 F. 3d 1077, 1081 (11th Cir. 2001) (internal citations omitted). "These requirements are the 'irreducible minimum' required by the Constitution for a plaintiff to proceed in federal court." Id. at 1081 (quoting Northeastern Fla. Chapter of Associated Gen. Contractors of America v. City of Jacksonville, 508 U.S. 656, 664 (1993)) (internal citations omitted). Additionally, in an action for injunctive relief, a plaintiff has standing only if the plaintiff establishes "a real and immediate–as opposed to a merely conjectural or hypothetical–threat of future injury." See Wooden v. Board of Regents of University System of Georgia, 247 F. 3d 1262, 1284 (11th Cir. 2001). A complaint that includes "only past incidents of discrimination" is insufficient to allege a real and immediate threat of future injury. See Shotz, 256 F. 3d at 1081.

Defendants do not attempt to contest that Plaintiff can satisfy each of these requirements. Instead, they appear to present a challenge to Plaintiff's ability to state a claim for relief under the ADA, as well as a potential defense - that Plaintiff's claims are barred by issue preclusion - or collateral estoppel. See Motion to Dismiss at 4; see Cope v. Bankamerica Hous. Serv., Inc., No. Civ.A. 99-D-653-N., 2000 WL 1639590, at *4 (M.D. Ala. Oct. 10, 2000). Upon review of Plaintiff's claims, the Court is fully satisfied that she has alleged an injury in fact, which is purportedly caused by the Defendants' actions, and for which a favorable decision by the Court would provide redress. Moreover, Plaintiff alleges a real and immediate threat of future injury. Thus, the Court determines that Plaintiff has standing to pursue the claims raised in this action. Moreover, neither of the challenges raised by Defendants in their "standing" discussion is actually a challenge to the Court's

subject matter jurisdiction. Thus, the Court will consider these arguments as challenges to Plaintiff's ability to succeed on the merits of her claims.

IV. STANDARD FOR RELIEF

A party seeking preliminary injunctive relief must establish that "(1) it has a substantial likelihood of success on the merits, (2) the movant will suffer irreparable injury unless the injunction is issued, (3) the threatened injury to the movant outweighs the possible injury that the injunction may cause the opposing party, and (4) if issued, the injunction would not disserve the public interest" before the district court may grant such relief. Horton v. St. Augustine, 272 F.3d 1318, 1326 (11th Cir. 2001) (citing Siegel v. LePore, 234 F.3d 1163, 1176 (11th Cir. 2000)); see also Int'l Cosmetics Exch. v. Gapardis Health & Beauty, Inc., 303 F.3d 1242, 1246 (11th Cir. 2002) (citing Levi Strauss & Co. v. Sunrise Int'l Trading Inc., 51 F.3d 982, 985 (11th Cir. 1995)). Additionally, "[i]t is well established in this circuit that a preliminary injunction is an extraordinary and drastic remedy not to be granted unless the movant clearly established the burden of persuasion as to all four elements." Siegel, 234 F.3d at 1176 (internal quotations and alterations omitted).

A typical preliminary injunction is prohibitive in nature and seeks simply to maintain the status quo pending a resolution of the merits of the case. See Mercedes-Benz U.S. Int'l, Inc. v. Cobasys, LLC, 605 F. Supp. 2d 1189, 1196 (N.D. Ala. 2009). When a preliminary injunction is sought to force another party to act, rather than simply to maintain the status quo, it becomes a "mandatory or affirmative injunction" and the burden on the moving party increases. Exhibitors Poster Exch. v. Nat'l Screen Serv. Corp., 441 F.2d 560, 561 (5th Cir. 1971). Indeed, a mandatory injunction "'should not be granted except in rare instances in

which the facts and law are clearly in favor of the moving party.'" Id. (quoting Miami Beach Fed. Sav. & Loan Ass'n v. Callander, 256 F.2d 410, 415 (5th Cir. 1958)); see also Martinez v. Mathews, 544 F.2d 1233, 1243 (5th Cir. 1976)[10] ("Mandatory preliminary relief, which goes well beyond simply maintaining the status quo pendente lite, is particularly disfavored, and should not be issued unless the facts and law clearly favor the moving party."). Accordingly, a plaintiff seeking such relief bears a heightened burden of demonstrating entitlement to preliminary injunctive relief. See Verizon Wireless Pers. Commc'n LP v. City of Jacksonville, Fla., 670 F. Supp. 2d 1330, 1346 (M.D. Fla. 2009) (quoting the Southern District of New York, "Where a mandatory injunction is sought, 'courts apply a heightened standard of review; plaintiff must make a clear showing of entitlement to the relief sought or demonstrate that extreme or serious damage would result absent the relief.'"); Mercedes-Benz, 605 F. Supp. 2d at 1196; OM Group, Inc. v. Mooney, No. 2:05-cv-546-FtM-33SPC, 2006 WL 68791, at *8-9 (M.D. Fla. Jan. 11, 2006).

Here, the parties disagree as to the nature of the relief sought. Plaintiff contends that because she merely seeks to prohibit unlawful discrimination, the injunctive relief she requests is prohibitive in nature and does not seek to change the status quo. However, Defendants argue that because Plaintiff is not currently receiving in-home health care services from Defendants, and requests that this Court order Defendants to provide her with such services, she seeks to change the status quo by requiring them to act. Because the Court determined that Plaintiff satisfied the heightened burden of demonstrating her

[10] In Bonner v. City of Prichard, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), the Eleventh Circuit adopted as binding precedent all the decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981.

entitlement to mandatory preliminary injunctive relief, the Court did not resolve the parties' dispute as to the applicable standard.

V. DISCUSSION

A. SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS

Title II of the ADA 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."[11] 42 U.S.C. § 12132. In the decision of Olmstead v. L.C. ex rel Zimring, 527 U.S. 581 (1999), the Supreme Court considered the application of this anti-discrimination provision in a rather unique context:

> we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions.

Id. at 587. The Court answered this question with a "qualified yes." See id. In doing so, the Court held that the unjustified institutional isolation of persons with disabilities is a form of discrimination by reason of disability. See id. at 597, 600-01. The Court explained:

> Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. 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. Dissimilar

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[11] Plaintiff's Rehab Act claim is essentially the same as her ADA claim, and discrimination claims of this kind are analyzed similarly under the two acts. See Allmond v. Akal Sec., Inc., 558 F.3d 1312, 1316 n.3 (11th Cir. 2009) ("Because the same standards govern discrimination claims under the Rehabilitation Act and the ADA, we discuss those claims together and rely on cases construing those statutes interchangeably."). Accordingly, the Court will refer primarily to the ADA for the sake of brevity.

> treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Id. at 600-01 (internal citations omitted). To avoid the discrimination inherent in the unjustified isolation of disabled persons, public entities are required to make reasonable modifications to policies, practices, and procedures for services they elect to provide. Nevertheless, the Olmstead Court recognized that a state's responsibility, once it determines to provide community-based treatment, is not without limits. See id. at 603.[12] Rather, the regulations implementing the ADA require only "reasonable modifications" and permit a state to refuse alterations to programs that will result in a fundamental alteration of the program or service. See id.

In considering whether a proposed modification is a reasonable modification, which would be required, or a fundamental alteration, which would not, the Olmstead Court determined that a simple comparison showing that a community placement costs less than an institutional placement is not sufficient to establish reasonableness because it overlooks other costs that the state may not be able to avoid. See id. at 604. The Court explained,

> 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.

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[12] "'[W]hile "[t]he section of Justice Ginsburg's opinion discussing the state's fundamental alteration defense commanded only four votes . . . [b]ecause it relied on narrower grounds than did Justice Stevens' concurrence or Justice Kennedy's concurrence, both of which reached the same ultimate result, Justice Ginsburg's opinion controls."'" Arc of Washington State Inc. v. Braddock, 427 F.3d 615, 617 (9th Cir. 2005) (quoting Sanchez v. Johnson, 416 F.3d 1051, 1064 n.7 (9th Cir. 2005), quoting Townsend v. Quasim, 328 F.3d 511, 519 n.3 (9th Cir. 2003)).

Id. Indeed, the Court recognized that the fundamental alteration defense must be understood to allow some leeway to maintain a range of facilities and services. See id.

> If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. . . . In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.

Id. at 605-06. Thus, having considered the ADA as well as the applicable regulations, the Court concluded that the ADA requires states to provide community based treatment for persons with disabilities when: (1) the state's treatment professionals have determined that community-based services are appropriate for an individual; (2) the individual does not oppose such services; and (3) the services can be reasonably accommodated, taking into account (a) the resources available to the state, and (b) the needs of others with disabilities. See id. at 602-04, 607; Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare, 402 F.3d 374, 379-80 (3d Cir. 2005); Frederick L. v. Dep't of Pub. Welfare of the Commonwealth of Pa., 364 F.3d 487, 493 (3d Cir. 2004); Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1181 (10th Cir. 2003). When these requirements are met, states must provide services to individuals in community settings rather than in institutions. See Fisher, 335 F.3d at 1181.

Before addressing the Court's conclusion that Plaintiff has established that she has a substantial likelihood of satisfying these requirements such that Defendants should be ordered, at this stage of the proceedings, to provide her with in-home services, the Court will first discuss Defendants' general challenges to Plaintiff's ability to pursue this action.

Defendants first argue that Plaintiff cannot state a claim of discrimination under the ADA because she is not being discriminated against "by reason of such disability" here because all in-home services waiver programs discriminate by their nature, providing services solely to disabled individuals and not to non-disabled individuals. See Response at 5-6; Motion to Dismiss at 4. However, the Eleventh Circuit and the Supreme Court have squarely rejected this argument. See Olmstead, 527 U.S. at 597-601 (affirming the finding of disability-based discrimination in L.C. v. Olmstead, 138 F.3d 893, 897-901 (11th Cir. 1998)). The unjustified institutional isolation of persons with disabilities is a form of disability-based discrimination that need not be accompanied by dissimilar treatment of non-disabled persons. See id. Indeed, in rejecting this same argument by the state in Olmstead, the Court specifically stated, "Congress had a more comprehensive view of the concept of discrimination advanced in the ADA," id. at 598, than the view espoused by the state. Therefore, Defendants' argument is not well taken.

Next, Defendants assert that Plaintiff's claims are barred by the doctrine of collateral estoppel. See Motion to Dismiss at 3-5. Specifically, Defendants explain that the issues underlying Plaintiff's claims were previously adjudicated by the settlement in the Dubois litigation, see Motion to Dismiss at 3-5, which resolved the claims of a class defined as encompassing "all individuals with traumatic brain or spinal cord injuries who the state has already determined or will determine to be eligible to receive services from Florida's Medicaid Waiver Program for persons with traumatic brain and spinal cord injuries and have not yet received such services," see Settlement (Doc. No. 32-2; Dubois Settlement) at 1.

The doctrine of collateral estoppel, also referred to as issue preclusion, bars the relitigation of issues that previously have been litigated and decided. See Irvin v. United States, 335 F. App'x 821, 822-23 (11th Cir. 2009); Christo v. Padgett, 223 F.3d 1324, 1339 (11th Cir. 2000). To apply collateral estoppel, the following elements must be present: "(1) the issue at stake is identical to the one involved in the prior proceeding; (2) the issue was actually litigated in the prior proceeding; (3) the determination of the issue in the prior litigation must have been 'a critical and necessary part' of the judgment in the first action; and (4) the party against whom collateral estoppel is asserted must have had a full and fair opportunity to litigate the issue in the prior proceeding." See Christo, 223 F.3d at 1339 (quoting Pleming v. Universal-Rundle Corp., 142 F.3d 1354, 1359 (11th Cir. 1998)). The principles of collateral estoppel are generally applicable to judgments entered in class actions like Dubois. See Cope, 2000 WL 1639590, at *5. However, while Defendants have provided the Court with a copy of the Dubois Settlement which was approved by the court, this single document is insufficient to establish that the first three prerequisites for collateral estoppel have been satisfied.[13] However, even if they are satisfied, a review of the Dubois

[13] Indeed, a cursory review of the Dubois Settlement raises significant questions about the Defendants' ability to satisfy the second and third elements. Paragraph H(2) of the Dubois Settlement agreement provides "all legal representations, including agreements based on legal claims, attributable to the Defendants as set out herein are solely and exclusively for the purpose of this settlement and shall not be binding on these Defendants or Plaintiffs in any other action or proceeding. . . ." See Dubois Settlement at 11. Thus, it appears that the parties to the Dubois Settlement specifically intended that their agreement not have any prospective preclusive effect. Moreover, the Dubois Settlement affirmatively provides "this agreement is not an admission of any wrongdoing or misconduct on the part of Defendants nor is it an admission by Plaintiffs that Defendant would have prevailed in this litigation." See id. at 8. In Cope, the court found the second element of collateral estoppel lacking where the settlement agreements at issue contained provisions indicating that the settlements did not constitute admissions of fault, liability or wrongdoing or an admission that the claims were valid. In doing so, the court noted that in accepting the prior settlement agreements, the reviewing court did not actually "determine" any issues bearing on the defendant's liability. See Cope, 2000 WL 1639590, at *9-10. Therefore, the common issues had not actually been litigated. See id. Here, the parties did not present (continued...)

Settlement establishes that Defendants cannot satisfy the fourth element. Thus, their collateral estoppel defense fails.

The Eleventh Circuit has found the "opportunity to litigate" element satisfied where a litigant was a party to the previous action, and was afforded a full and fair opportunity to address the issues in question. See Irvin, 335 F. App'x at 823; Christo, 223 F.3d at 1340. However, where a particular claim has not accrued at the time of the earlier proceeding, litigants cannot be said to have had a full and fair opportunity to litigate the issues. See In re Jennings, 378 B.R. 687, 696 (M.D. Fla. 2006) (full and fair opportunity to litigate requirement not satisfied where party had not yet been authorized to pursue a claim when the preceding adjudication occurred). Plaintiff was not a party to the Dubois litigation, nor was she a member of the class who would have had an opportunity to object to the settlement. This is so because Plaintiff did not suffer her injury until September 7, 2007, after the Dubois action was filed and even after the Dubois Settlement was signed and approved by the court. Accordingly, she had no opportunity to litigate her claims which had not yet accrued. See In re Jennings, 378 B.R. at 696.

Defendants' authorities in support of issue preclusion based on the Dubois Settlement are unavailing. In Reyn's Pasta Bella, LLC v. Visa USA, Inc., class members who were parties to the judicial proceedings were precluded from collaterally attacking a settlement agreement where they were part of the class and represented by counsel at the fairness hearing on the settlement agreement. See 442 F.3d 741, 746-47 (9th Cir. 2006). Similarly,

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[13](...continued)
argument regarding the satisfaction of these elements of collateral estoppel in any detail. Because the Court finds that the final element required for collateral estoppel is clearly lacking, it need not address these elements further.

in Carter v. Rubin, the court noted that "[c]ollateral estoppel, or issue preclusion, . . . bars 'relitigation of [an] issue in a suit on a different cause of action involving a party to the first case.'" See 14 F. Supp. 2d 22, 34 (D.D.C. 1998) (second alteration in original underline supplied). Unlike these plaintiffs, Plaintiff Haddad was not a party to the Dubois litigation.

In an effort to overcome this deficiency, Defendants assert that a strict reading of the class certified in Dubois establishes that Plaintiff is bound by that adjudication because she falls within the class definition which included "all individuals with traumatic brain or spinal cord injuries who the state has already determined or will determine to be eligible to receive services from Florida's Medicaid Waiver Program . . . and have not yet received such services." See Dubois Settlement at 1. However, Plaintiff could not have been a member of that class because, at the time the complaint was filed and the Dubois Settlement was signed and approved, she had no such injury. The language "who the state has already determined or will determine to be eligible to receive services" does not extend the class, ad infinitum, to all those for whom the state will ever make such a determination even though they had no injury at the time the Dubois Settlement was contemplated. Rather, this language plainly refers to those with such injuries at the time of the action, whether or not the state had determined their eligibility for services. Accordingly, Plaintiff's claims in this action are not barred by the Dubois Settlement.

Defendants also contend that the motion for preliminary injunction must be denied because the implementing regulations of the ADA do not create a private right of action, and therefore, Plaintiff has no claim. Defendants cite Am. Ass'n of People with Disabilities v. Harris, 605 F.3d 1124 (11th Cir. 2010) in support of this contention, but Harris is inapplicable

to the present case. In Harris, the plaintiffs filed suit against various state actors for failure to provide handicapped-accessible voting machines. See Harris, 605 F.3d at 1126-27. The district court dismissed the plaintiffs' claims under the ADA, Rehab Act, and the Florida Constitution and statutes, but permitted them to amend their complaint. See id. at 1127-28. The plaintiffs then filed a two-count amended complaint, asserting claims under the ADA and the Rehab Act. See id. at 1128. After a bench trial, the district court issued a declaratory judgment and an injunction against the Supervisor of Elections ("Supervisor") based not on a finding that he or any defendant violated the ADA or the Rehab Act, but rather based on a conclusion that the Supervisor of Elections violated the ADA's implementing regulation, 28 C.F.R. § 35.151(5), which deals with nondiscrimination on the basis of disability in state and local services. See id. at 1128-29. The Supervisor appealed the injunction, but while that appeal was pending, other circumstances rendered it moot. See id. at 1130. The district court then entered final judgment against the Supervisor in accordance with the declaratory judgment and injunction, which the Supervisor appealed. See id. at 1130-31.

In vacating the district court's judgment, the Eleventh Circuit noted that, although the amended complaint contained claims under the ADA and the Rehab Act, the judgment did not declare that the defendants had violated either of those statutes. See id. at 1131. In fact, there was no finding at all in regard to the ADA or the Rehab Act. See id. The district court's judgment was, instead, limited to finding a violation of the ADA's implementing regulation. See id. The Eleventh Circuit opined that it was unclear where the district court had found the authority to order the Supervisor to comply with the implementing regulation without first determining whether the ADA, itself, authorized such relief. See id. Indeed,

after performing such an analysis, the Eleventh Circuit held that there was no private right of action arising from the implementing regulation alone because congress placed available recourse within the ADA's express statutory right of action. See id. at 1132-35. Thus, absent a violation of the ADA, a violation of its implementing regulations would not create a private right of action and remedy. See id. at 1135-36.

Nevertheless, Harris' holding presents no bar to Plaintiff's claims because she is asserting a violation of the ADA, which does afford a private right of action. Indeed, Harris recognized that the ADA includes an express statutory right of action. See id. Moreover, the Supreme Court in Olmstead specifically found that unjustified isolation, under certain circumstances, can constitute a violation of the ADA. See 527 U.S. at 597. This is the basis of Plaintiff's action–not a violation of the ADA's integration mandate, separate from the ADA or the Rehab Act, as in Harris. Therefore, Harris presents no bar to Plaintiff's assertion of her right of action for a violation of the ADA based on unjustified isolation. See id. at 596-602; see also Crabtree v. Goetz, NO. CIV.A. 3:08-0939., 2008 WL 5330506, at *24 (M.D. Tenn. Dec. 19, 2008); Grooms v. Maram, 563 F. Supp. 2d 840, 851-854, 854 n.3 (N.D. Ill. 2008); Radaszewski v. Maram, No. 01 C 9551., 2008 WL 2097382, at *14 (N.D. Ill. Mar. 26, 2008). Defendants' arguments to the contrary simply reflect a mischaracterization of Plaintiff's claims. See Response at 5-6; Tr. at 36-38.

Alternatively, Defendants argue that Plaintiff cannot pursue her ADA claim because the Court must respect the plain language of the ADA regulations which instruct that a public entity need not provide personal care services. See Response at 6-10. Specifically, they rely on 42 C.F.R. § 35.135 which states that public entities are not required to provide

"services of a personal nature including assistance in eating, toileting, or dressing." Defendants contend that in light of this regulation, the ADA cannot be interpreted to require them to provide such services to Plaintiff. See id. at 6. However, Defendants' argument misses the mark. The ADA does not require states to provide a level of care or specific services, but once states choose to provide certain services, they must do so in a nondiscriminatory fashion. See Olmstead, 527 U.S. 581, 603 n.14; see also Fisher, 335 F.3d at 1182 (state may not amend optional programs so as to violate the ADA); cf. Rodriguez v. City of New York, 197 F.3d 611, 619 (2d Cir. 1999) (no ADA violation where plaintiffs requested service not already provided by defendant). Here, Defendants have elected to provide the services that Plaintiff requests through the TBI/SCI Waiver program. Having done so, they must provide them in accordance with the ADA's anti-discrimination mandate. Therefore, if Plaintiff is entitled to Medicaid services and is otherwise qualified for, desires, and requires TBI/SCI Waiver services in order to avoid unnecessary institutionalization, the ADA may, indeed, require Defendants to provide Plaintiff with such services if doing so would not result in a fundamental alteration of its programs.

Defendants' last broad challenge to the sufficiency of Plaintiff's claims is their argument that the ADA cannot abrogate or amend the Medicaid Act to make personal care services mandatory or to require Defendants to uncap their TBI/SCI Waiver program. See Response at 14-17. Specifically, Defendants contend that "the only way that Plaintiff's claims could be sustained is if the ADA were interpreted to amend (or partially repeal) the Medicaid Act by implication, by either amending/repealing 42 U.S.C. § 1396a(a)(10)(A), which makes personal care services optional for states" or by requiring states to provide

services under waiver programs. Response at 14. Indeed, Defendants conclude, "if the ADA's prohibition of discrimination 'by reason of . . . disability' amends the Medicaid Act, then surely the HCBS waiver programs would not survive." Response at 17. This is so, they argue, because waiver programs by their nature discriminate based on disability. The Court concludes that Defendants' arguments are unavailing.

First the Court rejects Defendants' contention that the success of Plaintiff's action requires a finding that the ADA invalidates or amends the Medicaid Act by mandating the provision of personal care services which are otherwise an optional benefit. Plaintiff's claim requires no such finding. A determination that Plaintiff Haddad should be provided the services at issue to avoid imminent institutionalization does not require a finding that states are required to provide personal care services as a mandatory Medicaid benefit. Indeed, Plaintiff is not seeking an order requiring Defendants to provide particular services through a waiver program, nor does she contend that the ADA prohibits states from imposing any limit on such programs. Instead, she contends that because Defendants have chosen to provide personal care services through the TBI/SCI Waiver to persons such as herself, Defendants must administer its provision of those services in compliance with the ADA. A state that chooses to provide optional services, cannot defend against the discriminatory administration of those services simply because the state was not initially required to provide them. Indeed, Defendants have provided no authority for the proposition that a state that chooses to provide Medicaid services, even if otherwise optional, would not be required to comply with the ADA in the provision of those services, just as it would have to comply with the ADA for any other "services, programs, or activities" provided by a public entity.

The Court finds similarly unavailing Defendants' contention that Plaintiff's claim requires the Court to invalidate 42 U.S.C. § 1396n(c)(1), (9) and (10), which make waiver programs voluntary and permit states to cap the enrollment in such programs.[14] No such relief is sought in this action. Plaintiff's claim simply addresses the question of whether these Defendants, having opted to provide particular services via the mechanism of a Medicaid Waiver Program, may be required, under the ADA, to provide those same services to her if necessary to avoid imminent, unnecessary institutionalization. Defendants attempt to characterize such a finding as an invalidation of the Medicaid Act is without merit.

Having dispensed with Defendants' general challenges to Plaintiff's ability to pursue the instant cause of action, the Court turns its attention to the determination set forth in the June 23, 2010 Order that Plaintiff has clearly established that she has a substantial likelihood of prevailing on the merits of her claims. As previously noted, the Olmstead Court determined that the ADA requires states to provide community based treatment for persons with disabilities when: (1) the state's treatment professionals have determined that community-based services are appropriate for an individual; (2) the individual does not

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[14] The Department of Health & Human Services, Center for Medicaid and State Operations Olmstead Update No: 4 supports this determination:

> May a state establish a limit on the total number of people who may receive services under an [in-home services] waiver? Yes. . . . The State does not have an obligation under Medicaid law to serve more people in the [in-home services] waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the [in-home services] waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

http://www.cms.gov/smdl/downloads/smd011001a.pdf ("Olmstead Update"); Reply at 9 (emphasis in original omitted; underline supplied).

oppose such services; and (3) the services can be reasonably accommodated, taking into account (a) the resources available to the state and (b) the needs of others with disabilities. See Olmstead, 527 U.S. at 602-604, 607.

It is undisputed that Defendants are public entities. Likewise, Defendants do not dispute that Plaintiff is a "qualified individual with a disability" who could be served in the community. Additionally, Plaintiff has provided ample evidence that she will have to enter an institution in order to receive the in-home services that would allow her to remain in the community and which Defendants provide through their TBI/SCI Waiver program. Indeed, Defendants have denied Plaintiff in-home services to date unless she first enters a nursing home so that funding for her services can be obtained from the Transition Plan. Thus, there is no dispute over the first two Olmstead factors. Plaintiff is on the waiting list as a qualified individual and Defendants admit she is medically eligible for institutional and waiver program care. Not only does Plaintiff not oppose receipt of in-home services, she describes herself as desperately seeking them. The only factor in question, then, is whether Plaintiff's requested accommodation, receipt of in-home services, is a reasonable accommodation in light of Defendants' resources and their obligations to other disabled individuals.

Defendants do not dispute that providing in-home services costs less than nursing home placement. As Plaintiff is qualified, and desires, to receive in-home services, and the provision of in-home services is cost-neutral,[15] the Court turns to the question of whether Plaintiff's requested accommodation would result in a fundamental alteration of Defendant's programs. See Radaszewski v. Maram, 383 F.3d 599, 614 (7th Cir. 2004) (reversing

[15] Indeed, in-home services are cost-saving rather than merely cost-neutral.

judgment in defendant's favor and remanding for consideration of whether the requested relief "is unreasonable or would require a fundamental alteration of the State's programs and services for similarly situated disabled persons."); Townsend v. Quasim, 328 F.3d 511, 519-20 (9th Cir. 2003) (reversing judgment and remanding for consideration of whether the modification requested would fundamentally alter the nature of services provided by the state); see also Fisher, 335 F.3d at 1180-81; Messier v. Southbury Training Sch., 562 F. Supp. 2d 294, 323 (D. Conn. 2008).

Defendants argue that Plaintiff's requested relief would constitute a fundamental alteration of its program because providing services to Plaintiff would cost more than Plaintiff's cost analysis indicates, as there are costs in the form of expanding its waiver program provider network which would be in addition to the added burden on their budget. Defendants also assert that they realize no savings unless an individual first enters a nursing home for a sufficiently long period of time. However, Defendant provided no evidence to support these arguments.[16] Beyond conclusory statements in the Response and at the hearing, Defendants have not shown how Plaintiff's cost analysis is flawed, how much an expansion of their provider network would cost, or why an individual must enter a nursing home facility for a certain period of time before Defendants realize any savings. While Defendants may be able to support these contentions on a more developed record, they have not done so here.

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[16] In the May 25 Order originally scheduling the Preliminary Injunction Hearing, the Court ordered the parties to submit all necessary evidence in advance of the hearing in accordance with Rule 4.06(b), Local Rules, United States District Court, Middle District of Florida (Local Rule(s)). Indeed, the hearing was continued in part to allow Defendants to obtain the necessary affidavits to present to the Court.

Additionally, the Court notes that if it costs less on a per day basis to provide in-home services instead of nursing facility care, it is unclear why Defendants would not realize some savings from the start. Defendants' contention appears to be based on the idea that if individuals are able to request and receive in-home services without first submitting to institutionalization, persons who are not truly at risk of institutionalization without state services, would nevertheless request provision of services at state expense. Thus, Defendants would be forced to spend funds for in-home services where no expenditure would otherwise be required. While this concern may have merit in the abstract, it has no application here. Based on the current record, Plaintiff has lost the provider of her necessary care. While her son stepped in to provide that care due to the exigent circumstances, his home and responsibilities in Miami, Florida will not permit him to continue to do so, and Plaintiff has no other source of care. While Defendants have suggested that they believe Plaintiff's actual risk of institutionalization is somewhat speculative, see id. at 62-63, the only evidence in the record supports a finding that Plaintiff is, indeed, on the threshold of involuntary institutionalization, see Haddad Dec. at 4-5; Johns Dec. at 5. Thus, while Defendants may be able to present testimony or evidence clarifying and supporting their concern, they have not done so at this time, and the evidence before the Court strongly suggests that such a concern has no application as to this particular Plaintiff.[17]

Moreover, to the extent Defendants' refusal to provide services is based on its financial structure, the Court notes that budgetary constraints, taken alone, are not enough

[17] The Court expresses no opinion as to the merit of such a challenge by others, under different circumstances, or where the challenge to Defendants' program is mounted on a more global basis.

to establish a fundamental alteration defense. See Pa. Prot. & Advocacy, Inc., 402 F.3d at 381. Factors relevant to a fundamental alteration defense certainly include the state's available resources, as well as its responsibility to other individuals. See Olmstead 527 U.S. at 604; Pa. Prot. & Advocacy, Inc., 402 F.3d at 380. However, Defendants have pointed to no evidence, save for the single statement in the Russell Affidavit I that "[i]f the TBI/SCI Waiver Program were forced by court order to place Ms. Haddad in the program, we would have to reduce services that others in the TBI/SCI Waiver Program are currently receiving." Russell Aff. I at 2. However, where as here, the evidence is in conflict as to whether the TBI/SCI Waiver is actually full, this assertion is insufficient to support a fundamental alteration affirmative defense. Moreover, Defendants have failed to address other funding alternatives or to explain how being required to provide services to Plaintiff will undermine their ability to provide proper care to the state's disabled population. Indeed, Defendants provided no evidence that providing services to Plaintiff would cause their programs to suffer or be inequitable given the state's responsibility to provide for the care and treatment of its diverse population of persons with disabilities. Such evidence would certainly have been relevant to Defendants' fundamental alteration defense.

Additionally, the Court finds that on the current limited record, Defendants have simply failed to show that they have a comprehensive, effectively working plan in place to address unnecessary institutionalization. See id. at 381-82 (finding a comprehensive effective plan to be a prerequisite to mounting a fundamental alteration defense). In discussing the fundamental alteration defense, the Court in Olmstead recognized that if a state "had a comprehensive, effectively working plan for placing qualified persons with

[disabilities] in less restrictive settings, and a waiting list that moved at a reasonable pace, not controlled by the state's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met" and the Court would have no reason to interfere. Olmstead, 527 U.S. at 605-606. Following this guidance, in Arc of Washington State Inc. v. Braddock, 427 F.3d 615, 621 (9th Cir. 2005), the Ninth Circuit determined that the state of Washington's waiver program provided such an effective comprehensive plan such that the ADA required no modification. In doing so, the court noted that the waiver program was full, had a waiting list with turnover, all eligible individuals had an opportunity to participate in the program once space became available, slots had been increased when appropriate, expenditures more than doubled despite significant cutbacks or minimal budget growth in the agencies, and the institutionalized population declined by 20%. See id. at 621.

The record before the Court contains no similar evidence. Defendants have only shown that the various waiver programs have increased in size and expenditures. See Hudson Aff. at 1-3; see also Makin ex rel. Russell v. Haw., 114 F. Supp. 2d 1017, 1035 (D. Haw. 1999) (only showing an effort to decrease waiting list by increasing slots, without evidence of a plan, did not show that the state was complying with the ADA). However, this does not address the effectiveness of the TBI/SCI Waiver program. Indeed, Defendants were unable to provide the Court with even the most basic factual information in regard to the waiver program and its waiting list. Defendants did not know Plaintiff's place on the waiting list beyond the fact that she was not in the top forty-five. See Tr. at 51-52. Defendants provided no information as to the average time spent on the waiting list or the rate of turnover, see id. at 54, 102-03, although Plaintiff has been waiting for approximately

two-and-a-half years. Defendants' evidence was in conflict as to whether the TBI/SCI Waiver program was full. See id. at 60-62; 96-98. While Defendants argued that they are committed to decreasing the institutionalized population, they did not present evidence that it has steadily declined.[18] Indeed, contrary to Defendants' assertion of a comprehensive effective plan, the evidence suggests that Defendants' plan may well be ineffective given that their last representation to Plaintiff advised:

> [p]resently, the Department of Children and Families does not have funds available (or available openings) to serve additional individuals through these programs. . . . Placement on the waiting list does not ensure future eligibility. Funding is very limited in these programs, and the amount of funding allocated to these programs has not been increased in many years. Unfortunately, moving individuals off the waiting list into these programs does not occur frequently, therefore, we encourage you to continue seeking services from other programs.

January 8, 2010 Letter at 1. Moreover, despite Plaintiff having informed Defendants of the change in her circumstances in March 2010, Plaintiff has not been reassessed in regard to her priority on the waiting list for the TBI/SCI Waiver. See Haddad Dec. at 4; Tr. at 115-16.

Instead of providing evidence that they have in place an efficient comprehensive plan to avoid institutionalization, Defendants offer the alternative that Plaintiff enter a nursing home for at least sixty days and then be transitioned out of the institution and provided in-home services thereafter. See Tr. at 73-75. This proposal simply gives Defendants an alternative funding source for provision of the services Plaintiff requires. Thus, to satisfy Defendants' budgetary structure, an individual must run the gauntlet of institutionalization for at least sixty days in order to receive in-home services. See id. 105-07. Defendants

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[18] Counsel made some representations regarding numbers based on "his understanding" but presented no evidence in support of that understanding.

have, on the current record, failed to show that such a deprivation is necessary to effectively provide care and treatment for the diverse population of persons with disabilities. Rather than providing for a proper assessment of need which may obviate the need for individuals to meet such a threshold, Defendants appear to be shifting the unnecessary burden of institutionalization onto Medicaid recipients. Accordingly, on the current record, Defendants' fundamental alteration defense is not sufficiently supported, and Plaintiff established that the law and facts at this stage clearly indicate she is likely to prevail on the merits of her case.

B. IRREPARABLE INJURY

Defendants argue that Plaintiff is unlikely to suffer irreparable injury because she will only be institutionalized temporarily. However, Defendants candidly acknowledge that they cannot assure the length of time in question, or that it is truly finite. Indeed, Defendants admit that upon the expiration of the sixty-day period, Plaintiff, who has been living successfully in the community for the last two and a half years, would have to be assessed by the state and be found to be safe for community placement. Accordingly, all Defendants can guarantee is that Plaintiff will face at least sixty days of institutionalization. See id. at 19, 73-75. The requirement that Plaintiff first enter a nursing home in order to be transitioned out sometime thereafter presents Plaintiff with exactly the kind of uncertain, indefinite institutionalization that can constitute irreparable harm. See Katie A. v. L.A. County, 481 F.3d 1150, 1156-57 (9th Cir. 2007) (though it applied an erroneous legal interpretation of the Medicaid statute, district court found unnecessary institutionalization that would occur absent a preliminary injunction to be irreparable harm); Long, 2008 WL 4571903, at *2 (if preliminary injunction was not issued, plaintiff would have to re-enter

nursing facility, which would inflict irreparable injury); McMillan v. McCrimon, 807 F. Supp. 475, 479 (C.D. Ill. 1992) ("possibility that the plaintiffs would be forced to enter nursing homes constitutes irreparable harm that cannot be prevented or fully rectified by a judgment later"). Moreover, Plaintiff's physician has indicated that institutionalization will be detrimental to Plaintiff's health and well-being. See Johns Dec. at 5 ("if [Plaintiff] were placed in a nursing home she would quickly become depressed and her health would most likely deteriorate"); see also Marlo M. v. Cansler, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) (plaintiffs would suffer regressive consequences); Long, 2008 WL 4571903, at *2 (plaintiff would suffer "enormous psychological blow"). Therefore, Plaintiff clearly established that she is at risk of irreparable injury if required to enter a nursing home.

C. BALANCE OF HARMS

Additionally, Defendants admit that "if [Plaintiff] were to go into a nursing home tomorrow, okay, or today or next week or whatever, then clearly the balance of hardships would tip in her favor. . . . Hypothetically, that if she were to enter a nursing home, then yes, the balance of hardships would tip in her favor." Tr. at 65. But Defendants argue that Plaintiff's entry into a nursing home is speculative, and therefore, if Plaintiff would not be institutionalized for months or a year, the balance of harm would swing in Defendants' favor. See id. However, as previously noted, the Court is satisfied that Plaintiff established that she is, indeed, on the threshold of unnecessary institutionalization. See Haddad Dec. at 4-5; Johns Dec. at 5; Tr. at 83. Accordingly, the balance of harms clearly lies in Plaintiff's favor.

D. THE PUBLIC INTEREST

Likewise, the public interest favors preventing the discrimination that faces Plaintiff so that she may avoid unnecessary institutionalization. See Olmstead, 527 U.S. at 599-01. The public interest also favors "upholding the law and having the mandates of the ADA and Rehabilitation Act enforced," as well as in providing injunctive relief that "will cost less than the alternative care proposed by Defendants. As the funding originates from tax dollars, the public interest clearly lies with maintaining Plaintiffs in the setting that not only fulfills the important goals of the ADA, but does so by spending less for Plaintiffs' care and treatment." See Marlo M., 679 F. Supp. 2d at 638-39; see also Long, 2008 WL 4571903, at *3.

VI. CONCLUSION

In consideration of the foregoing, the Court determined that Plaintiff made a clear showing that she has a significant and substantial likelihood of succeeding on the merits of her claim, that Defendants' refusal to provide her with in-home based health care services for which she is financially and medically eligible, and which Defendants provide to others through the TBI/SCI Medicaid waiver program violates the ADA; that she will suffer irreparable injury unless the injunction is issued in that she is at imminent risk of being institutionalized in order to obtain the necessary services which Defendants refuse to provide her outside the institutional setting; that the threatened injury to Plaintiff outweighs the possible injury that the limited injunctive relief ordered here may cause Defendants; and

that such an injunction would not disserve the public interest.[19] Accordingly, the Court entered its June 23, 2010 Order granting preliminary injunctive relief in this action.

DONE AND ORDERED in Jacksonville, Florida, this 9th day of July, 2010.

Marcia Morales Howard

MARCIA MORALES HOWARD
United States District Judge

Copies to:

Counsel of Record

[19] Again, the Court cautions that its findings in this Opinion are strictly limited to the unique circumstances currently facing Plaintiff, Michele Haddad, and are based upon the limited record now before the Court. Thus, this Court's determination that preliminary injunctive relief is appropriate should not be interpreted as suggesting that the Court will find such relief warranted under circumstances different from those here, or that Defendants, on a more complete record, cannot establish that such relief would constitute a fundamental alteration of their programs or that they have a comprehensive, effectively working plan for providing services to qualified individuals with disabilities obviating the need for such relief.