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

ORIGINAL

Civil Action File No. 1:95-CV-1210 MHS

L.C. AND E.W., BY JONATHAN ZIMRING AS GUARDIAN AD LITEM AND NEXT FRIEND,

Plaintiffs,

v.

TOMMY OLMSTEAD, COMMISSIONER OF THE DEPARTMENT OF HUMAN RESOURCES; RICHARD FIELDS, SUPERINTENDENT OF GEORGIA REGIONAL HOSPITAL AT ATLANTA; AND ERNESTINE PITTMAN, EXECUTIVE DIRECTOR OF THE FULTON COUNTY REGIONAL BOARD, ALL IN THEIR OFFICIAL CAPACITIES,

Defendants.

PLAINTIFF E.W.'S MOTION FOR A PRELIMINARY INJUNCTION

SUSAN C. JAMIESON
Georgia State Bar No. 389408

CHARLES BLISS
Georgia State Bar No. 063385

340 W. Ponce de Leon Avenue
Decatur, Georgia 30030
(404) 377-0701

STEVEN D. CALEY
Georgia State Bar No. 102866

SYLVIA B. CALEY
Georgia State Bar No. 611240

151 Spring Street, N.W.
Atlanta, Georgia 30303-2097
(404) 614-3926

ATTORNEYS FOR PLAINTIFFS

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

L.C. and E.W., by JONATHAN ZIMRING as guardian ad litem and next friend, Plaintiffs, vs. TOMMY OLMSTEAD, Commissioner of the Department of Human Resources; RICHARD FIELDS, Superintendent of Georgia Regional Hospital at Atlanta; and ERNESTINE PITTMAN, Executive Director of the Fulton County Regional Board, all in their official capacities, Defendants.	)	CIVIL ACTION FILE NO. 1:95-CV-1210 MHS

PLAINTIFF E.W.'s MOTION FOR A PRELIMINARY INJUNCTION

Plaintiff E.W. hereby moves this Court for a preliminary injunction, pursuant to Fed. R. Civ. Pro. 65, for the reasons set forth in Plaintiff's accompanying brief. Specifically, Plaintiff seeks an injunction directing Defendants to comply with the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq., and release her from Georgia Regional Hospital - Atlanta, a mental hospital, to an appropriate, integrated community setting.

Such a setting would include (1) comprehensive multi-disciplinary assessments; (2) transportation to and from medical and psychiatric appointments; (3) regular medical care with special attention to E.W.'s weight control and urinary incontinence; (4) frequent monitoring of any prescribed psychotropic drugs and ongoing assessments to determine whether psychotropic drugs are indicated; (5) vocational and leisure programs; (6)

continuing day habilitation in a structured setting; (7) crisis management; (8) psychiatric oversight; (9) behavioral monitoring and interventions as indicated; and (10) contact with family in a supportive environment.

Plaintiff has no adequate remedy at law. Her rights can be protected and preserved only by the issuance of an Order enjoining the Defendants from continuing to violate these rights.

Respectfully submitted,

Susan C. Jamieson (by s/s w/express permission)
SUSAN C. JAMIESON
Georgia State Bar No. 389408

CHARLES BLISS
Georgia State Bar No. 063385

340 W. Ponce de Leon Avenue
Decatur, Georgia 30030
(404) 377-0701

Steven D. Caley
STEVEN D. CALEY
Georgia State Bar No. 102866

SYLVIA B. CALEY
Georgia Bar No. 611240

151 Spring Street
Atlanta, Georgia 30303-2097
(404) 614-3926

Attorneys for Plaintiffs

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Defendants.

PLAINTIFF E.W.'S BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

SUSAN C. JAMIESON
Georgia State Bar No. 389408

CHARLES BLISS
Georgia State Bar No. 063385

340 W. Ponce de Leon Avenue
Decatur, Georgia 30030
(404) 377-0701

STEVEN D. CALEY
Georgia State Bar No. 102866

SYLVIA B. CALEY
Georgia State Bar No. 611240

151 Spring Street, N.W.
Atlanta, Georgia 30303-2097
(404) 614-3926

ATTORNEYS FOR PLAINTIFFS

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BRIEF IN SUPPORT OF PLAINTIFF E.W.'S MOTION FOR A PRELIMINARY INJUNCTION

INTRODUCTION

Plaintiff, E.W., asks this Court to grant her motion for preliminary relief because she has been and remains in a state psychiatric institution, Georgia Regional Hospital - Atlanta (GRH-A), a highly segregated and isolated facility, despite the fact that her needs can be met more appropriately in an integrated, community-based program. The type of program that E.W. needs exists in the community, and, in fact, a provider of community services is willing and able to serve E.W. if funding is made available. (See affidavit of Dr. Richard Elliott, ¶¶ 14 and 15, Exh. 1).

When E.W.'s Motion to Intervene in this case was granted in late January 1996, she had been hospitalized for more than a year. By the time that discovery had been completed at the end of June 1996, it was apparent that the Defendants had made no progress toward identifying a community placement for E.W. Defendants' own professionals agree that E.W. can be served in a more integrated, community program. Her physician, Dilipkumar Patel, M.D., presents Plaintiff's own inquiry to this Court succinctly:

> Q. If you were aware of a provider who could meet her needs in the community, would you be in favor of placing her in the community?
>
> A. Yes, why not?

(Patel dep. at 76, l. 25, 77, l. 1-4, Exh. 2).

The abject failure of the Defendants to so place E.W. violates the Americans With Disabilities Act and its implementing regulations which provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (Emphasis added). While Defendants illegally refuse to integrate E.W. into an appropriate community placement, her condition continues to deteriorate.[1]

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[1]This case was filed initially on May 11, 1995 by Plaintiff L.C. who was also institutionalized at GRH-A despite qualifying for a community placement as admitted by Defendants' own treatment staff. After Plaintiff filed two motions for temporary restraining orders, Defendants finally placed L.C. in a community residential program in February 1996 where L.C. has begun to adjust successfully to life outside an institution.

STATEMENT OF FACTS

I. PLAINTIFF E.W.'s HISTORY AND CURRENT PLIGHT

E.W., age 43, is mentally retarded. As an infant at about one year of age, she contracted meningitis accompanied by a high fever that left her with brain damage. She attended special schools as a young child, but her behavior problems eventually could not be managed at home. At age 15, she was placed at Gracewood, a state institution for the mentally retarded, where she remained for five years.

After E.W. was discharged from Gracewood in 1975, she tried to survive on her own in Atlanta but after another lengthy institutionalization at a state hospital in Milledgeville, Georgia, a pattern soon developed of multiple admissions to GRH-A. E.W. has had over thirty admissions to GRH-A in the past twenty years. (See Exhibit 3 attached to Parrish dep. and identified at 40, l. 25 - 44, l. 9-14, Exh. 10).

As a result of E.W.'s lengthy institutionalization, Dr. DeBacher, a GRH-A staff psychologist, now believes that E.W.:

> . . . has become so worn out in this environment that she would benefit from a complete change of scene to help her climb out of her depression and take a renewed interest in life. Our hospital was never intended for long-term habilitation (except DLC which serves lower functioning retardates), and our relatively Spartan physical and social environment is intended to inspire patients to return quickly to life outside. It is unavoidably lacking as a long-term growth environment.

(DeBacher evaluation of E.W. at 6, ¶ 4, Exh. 12).

E.W. needs an appropriate, supervised placement in a community residential program rather than repeated, prolonged, and unnecessary institutionalization in state psychiatric hospitals. Dr. DeBacher, in his evaluation, specifically noted that the hospital

environment was counter-productive for E.W. and that E.W.'s needs relating to socialization, vocational rehabilitation, and behavioral learning could be adequately met only in an integrated community program with appropriate supports and staff. (DeBacher eval., Exh. 12). He was also clear that it is only the lack of an available community alternative that explains E.W.'s lengthy psychiatric institutionalization:

> Q. If you had a home provider who said they would be willing to take her, do you think it would be a good idea to give her a try in the community?
>
> A. You mean a staffed group home or just an individual provider?
>
> Q. A staffed group home that can provide the things you indicated a group home should do.
>
> A. Sure, yeah.
>
> Q. At what point do you think it would have been good to try?
>
> A. Well, as soon as we would have known about such a place and had about a month to prepare to, you know, based on her current situation and let her see the place; let them get to know her; talk about contingencies; trial visit there for a while; you know, give her some encouragement for doing okay.

(DeBacher dep. at 46, l. 6-23, Exh. 14).

Dr. DeBacher, in assessing E.W., reviewed the report of Dr. June Kaufman, another psychologist who, according to Dr. DeBacher, "has considerable experience in evaluating developmental disabilities" (DeBacher eval. of E.W. at 2, ¶ 5, Exh. 12). Dr. Kaufman also concluded that E.W. "needs to have a highly structured residential home appropriate for an individual with mental retardation and behavioral/emotional deficits. She also needs to be involved in a sheltered workshop program appropriate for a mentally retarded individual who has been institutionalized many times due to possible

inappropriate placements." (Kaufman evaluation of E.W. at 4, "Summary and Recommendations," Exh. 15).

Drs. DeBacher and Kaufman are not the only persons who believe E.W. can be placed successfully in the community. As noted above, her treating physician, Dr. Patel, favors placing her in the community with proper supports. (Patel dep. at 25, l. 16-22; 33, l. 2-5; 75, l. 9-21; 76, l. 25 - 77, l. 4, Exh. 2). Similarly, Charles Bliss, the social work supervisor at GRH-A who is responsible for coordinating E.W.'s treatment believes that E.W. does not belong in the hospital except during an acute crisis. (Bliss dep. at 47, l. 18; 48, l. 13, Exh. 3). Joseph Steed, a behavioral consultant with the Defendant Fulton County Regional Board who is responsible for making placement assessments, concluded that E.W. could be placed in a group home that provided appropriate treatment. (Steed dep. at 61, l. 7-9; 65, l. 19-22; 66, l. 5, Exh. 4).

Finally, Dr. Richard Elliott, an expert in both mental health and mental retardation retained by Plaintiffs in this case has stated unequivocally that E.W. should be placed in the community and that specific providers exist who can provide E.W. the necessary services. (Aff. of Dr. Richard Elliott, ¶¶ 11 and 15, Exh. 1; Elliott dep. at 29, l. 6-10; 77, l. 14-24, Exh. 5). Virtually everyone agrees that capable providers exist in the community. (Patel dep. at 26, l. 20-21, Exh. 2; DeBacher dep. at 29, l. 8-10, Exh. 14; Ingram dep. at 16, l. 14-16; 33, l. 6-8, Exh. 6). Indeed, one specific provider who is aware of E.W.'s treatment and habilitation needs would be happy to serve E.W. and is capable of doing so. (Elliott Aff., ¶¶ 14 and 15, Exh. 1).

Despite the weight of opinion that E.W. can and should be provided an appropriate community placement, it has not occurred due simply to Defendants' refusal to fund it. Dr. DeBacher testified that private companies could provide the necessary services if the funds were made available and that a staffed group home could have been tried at the end of summer 1995 if it had been available. (DeBacher dep. at 29, l. 1-22; 46, l. 6-23; 47, l. 1-7, Exh. 14).

Defendant Fields testified that persons are often ready for the community but are not placed due to lack of funds. (Fields dep. at 61, l. 19-23, Exh. 7). Yet, he noted that 90% of the Mental Health, Mental Retardation, and Substance Abuse Division's dollars go to hospitals, leaving only 10% for community placements. (Id. at 65, l. 1-8). This is true despite the Georgia legislature passing House Bill 100, O.C.G.A. § 37-2-1 et seq., in 1993 giving the Mental Health, Mental Retardation, and Substance Abuse Division of DHR the authority to move more monies from hospitals to community services. O.C.G.A. § 37-2-5.1(c). The vision behind H.B. 100 was that this transfer of monies would actually occur so that more people would be served in the community at less cost. (Elliott dep. at 122, l. 1-6, Exh. 5).

A simple example of how community care costs less in the long-term can be shown by looking at the Mental Retardation Waiver Program. This program is designed to allow states to place people in less expensive community placements who would otherwise be eligible for care in an intermediate care nursing facility for the mentally retarded (ICF/MR). 42 U.S.C. § 1396n(c). For the fiscal year 1997, Georgia projected the average per capita annual costs for ICF/MR placement (mental retardation

institutional care) to be $72,267 and for the Mental Retardation Waiver Program (community placement) to be $39,359. (Excerpt from Georgia's Section 1915(b) Waiver Request, Appendix C2/C3, Exh. 19). However, community placement supervisors are reluctant to use this program because they believe it would require the state to permanently close institutional beds. (Bliss dep. at 34, l. 2-3, Exh. 3).

Willie Ingram who is the Director of the Disabled Learning Center (DLC) at GRH-A[2] and Defendant Olmstead have supplied additional information comparing the relative costs of institutional care and community care for the mentally retarded. Mr. Ingram has testified that the Medicaid waiver program per diem cost for community placements is approximately $118 to $124. On the other hand, the per diem cost for institutional care at the DLC is $283. (Ingram dep. at 58, l. 1-7; 59, l. 4-6, Exh. 6). On an annual basis, therefore, institutional care for the mentally retarded costs more than twice as much as community care, or almost $60,000 more per person per year.

With respect to the cost of care for the mentally ill, Defendant Olmstead has provided information showing similarly dramatic differences in cost. The cheaper "adult psychiatric" per diem rate for institutional care at the Treatment Unit of GRH-A is $232 or $84,680 on an annual basis. The more expensive "extended care" per diem cost is $505 or $184,325 per year. (Defendant Olmstead's Answer to Plaintiffs' Interrog. No. 21, Exh. 18). As with care for the mentally retarded, the cost of institutional care for the mentally ill is substantially more expensive than the cost of community care.

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[2]GRH-A has two primary units, the Disabled Learning Center and the Treatment Unit. The Disabled Learning Center is charged with providing care for the mentally retarded. The Treatment Unit is charged with providing treatment for the mentally ill.

Charles Hopkins, a program consultant for the Division, admitted that more persons could be served if the state allocated more money to match substantial available federal dollars. Although the federal government has authorized matching federal dollars to fund 2,109 community placements through the Medicaid waiver program, the State of Georgia is using only 700 of those slots. (Hopkins dep. at 18, l. 14-19; 19, l. 3-6, Exh. 8). In addition to these and other dollars, the Division has $300,000 in discretionary funds that can be used for community placements. (Hopkins dep. at 24, l. 14-18, Exh. 8).

Instead of funding more community placements, the Division, as noted in a Division press release which Defendant Olmstead assumed was accurate, employs and pays for 99% of its 11,000 employees to work in state institutions rather than in the community. (Olmstead dep. at 71, l. 5-9, Exh. 9). Defendant Olmstead also acknowledged that although hospitals could be down-sized and still fulfill their mission (id. at 51, l. 22-25), over the last four years, funding for mental retardation community residential services has decreased by almost $3,000,000 and mental health supportive living funding has decreased by over $12,000,000.[3] At the same time, mental health institutional funding has increased by over $19,000,000. (Id. at 23, l. 23-25; 24, l. 1-10). These significant changes occurred after the Georgia legislature passed H.B. 100 to encourage more spending for community services and less spending for institutional care.

[3]Mental retardation community residential funding is used for actually placing a mentally retarded person in a residential setting. Mental health supportive living funding is used for actually placing a mentally ill person in a residential setting.

Because of these funding decisions, the only actual community placements E.W. has received have been in personal care homes which provide room and board to mentally ill persons with very limited income, typically Supplemental Security Income. Defendant's own staff admit that these homes do not provide the appropriate level of trained supervision and support that E.W. needs. (DeBacher dep. at 22, l. 19-25, Exh. 14; Parrish dep. at 35, l. 3-5; 66, l. 3-5 & 11-16; 78, l. 13-23; 79, l. 2-5, Exh. 10).

More specifically, Jimmie Parrish, E.W.'s case manager from October 1994 to August 1995, candidly admitted that E.W.'s placement at the Ponce Manor personal care home on December 29, 1994 was inappropriate. (Parrish dep. at 65, l. 9-13, Exh. 10). As a result of this placement, E.W. had to be re-hospitalized. Similarly, Mr. Parrish admitted that E.W.'s placement at the Stewart Avenue personal care home four days later on January 4, 1995, where the home provider "tried to pray the demons out of her", was inappropriate. (Id. at 69, l. 7-11). As a result of this experience, E.W. was re-hospitalized on January 17, 1995. Shortly thereafter, on February 7, 1995, E.W. was placed at Graves Personal Care Home. (Id. at 75, l. 1-13). At this point, Mr. Parrish admits that he did not even know what constituted appropriate placement (id. at 77, l. 14-15) but acknowledged that E.W. had not been placed in appropriate programs that would break the cycle of re-hospitalizations. (Id. at 78, l. 3-23).

Mr. Parrish also admits that E.W.'s problem was related to her mental retardation, yet no mental retardation program was even considered for E.W. In fact, when Mr. Parrish was assigned the task of seeking mental retardation services for E.W., he did nothing. (Id. at 79, l. 11-14). Mr. Parrish also admits that he did not know if any

personal care homes, including the placements described above, could provide the necessary behavioral management services for E.W. (Id. at 83, l. 8-24; 84, l. 8-16), yet E.W. was so placed anyway because Mr. Parrish still did not know of any personal care homes that provided those services. (Id. at 78, l. 13-20; 79, l. 2-5).

Given that E.W.'s treatment staff knew from the outset that E.W. needed services in the community that the personal care homes admittedly could not provide, it should have come as no surprise that those placements failed. Rather than search for providers who could supply appropriate services or furnish the necessary funding to insure that such services would be provided, Defendants next sought to discharge E.W. to a homeless shelter. (Patel dep. at 20, l. 25; 21, l. 1-3, Exh. 2; Parrish dep. at 94, l. 9-12, Exh. 10). This is a common practice when patients have no income. (Parrish dep. at 92, l. 20 - 94, l. 25, Exh. 10).

The discharge to a homeless shelter was planned with no provision for mental health services, mental retardation services, or medical services for E.W.'s urinary incontinence. Several persons on E.W.'s treatment team later acknowledged that such a placement was inappropriate and would probably result in re-hospitalization. (Parrish dep. at 96, l. 11 - 97, l. 3, Exh. 10; Steed dep. at 93, l. 8-11, Exh. 4; Bliss dep. at 86, l. 5-9, Exh. 3). Plaintiff's expert, Dr. Elliott strongly agrees. (Elliott dep. at 97, l. 19 - 99, l. 3, Exh. 5). Fortunately for E.W., the planned placement was aborted when present counsel for E.W. objected.

After the attempted discharge to a homeless shelter was thwarted, case management staff met in April 1995 and directed the case manager, Mr. Parrish, to

explore other placement options that would include mentally retarded services. From April 1995 to September 1995, however, Mr. Parrish admitted that he made no such efforts. (Parrish dep. at 106, l. 12 - 109, l. 20, Exh. 10). Ms. Bess Ligon, who replaced Mr. Parrish as E.W.'s case worker in September 1995, similarly did nothing for months, failing to even speak with Defendant Shepard of the Fulton County Regional Board until February 1996. (Ligon dep. at 10, l. 2-6; 28, l. 17-25; 29, l. 1-2, Exh. 13).[4]

As of this date, E.W. has not been placed in the community. In the meantime, her condition is deteriorating. (Steed dep. at 70, l. 22-24, Exh. 4). It will continue to deteriorate if E.W. is not given appropriate services including a community placement. (Elliott aff. at ¶¶ 12 and 16, Exh. 1).

With no end in sight to her inappropriate isolation and segregation at GRH-A, E.W., in the past four months has become increasingly unhappy and frustrated. On March 20, 1996, for example, this entry appears in her hospital record, "Patient requests to write in her chart that she wants to be discharged. . . . Memo will be left under Patel's door." (GRH-A record, progress note, March 20, 1996, Exh. 11). On several occasions, she has tried to leave the institution and was returned to her treatment unit by facility police. One of the consequences for these "AWOL" attempts has been a reduction in E.W.'s "level" so that she has even less freedom within the institution. She has tried to

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[4]The Regional Board was and is responsible for community placements under the Medicaid waiver program for mentally retarded persons. Interestingly, Ms. Ligon's efforts, other than one unanswered telephone call in November 1995, did not begin until shortly after this court granted E.W.'s Motion to Intervene in this case on January 29, 1996.

leave GRH-A at least four times since the beginning of April 22, 1996. (GRH-A record, progress notes, April 23, 27, May 7, and June 21, 1996, Composite Exhibit 11).

II. PROGRAMS THAT MEET E.W.'S NEEDS EXIST IN THE COMMUNITY

The most obvious example in this litigation of the existence of appropriate community programs is the placement where L.C., the original Plaintiff in this case, is currently residing. It is a 24-hour staffed residence operated by a team with wide experience in mental retardation. The staff support services are funded, in part, through the Mental Retardation Waiver Program (MRWP) described earlier. The MRWP provides a flexible funding mechanism for providing needed community services, including residential services, to mentally retarded adults so that they can leave more expensive institutional care and reside in the community.

L.C.'s case management services are provided through ACCESS, a community-based mental health program which has psychiatric outreach workers and a psychiatrist. (Thornton dep. at 41, l. 22-25; 42, l. 1-15, Exh. 16). During the day, L.C. is engaged in supervised work, leisure, socialization, and educational activities. (See Access Plan, Exh. 17).

Community mental retardation and mental health programs have existed in Georgia for many years, although Georgia has continued to rely heavily on expensive, institutional programs. In addition to the MRWP program, there are community residential programs and other community services for mentally ill persons. (Defendant Olmstead's Answers to Plaintiffs' Interrog. Nos. 2-8, Exhibit 18). Plaintiffs' expert, Dr. Richard Elliott, as already noted above, has specifically identified one such program that

is familiar with E.W. and is willing and capable of serving her. (Elliott aff. at ¶¶ 14 and 15, Exh. 1). Despite the existence of these programs, their cost-effectiveness as described earlier, and E.W.'s eligibility for these programs, Defendants refuse to act. In the meantime, E.W. continues to languish at GRH-A losing hope that she will ever live in the community and receive the services that she needs.

ARGUMENT AND CITATION OF AUTHORITY

I. STANDARD FOR GRANTING A PRELIMINARY INJUNCTION

Under Fed. R. Civ. P. 65, Plaintiff E.W. is entitled to a preliminary injunction if she demonstrates (1) a substantial likelihood of success on the merits; (2) a threat of irreparable injury if the preliminary injunction is not granted; (3) an irreparable injury that outweighs the harm the preliminary injunction will cause to the Defendants; and (4) the preliminary injunction is in the public interest. Ingram v. Ault, 50 F.3d 898 (11th Cir. 1995); Baker v. Buckeye Cellulose Corporation, 856 F.2d 167, 169 (11th Cir. 1988). As will more fully appear below, Plaintiff E.W. meets these standards and is entitled to a preliminary injunction in this case.

II. E.W. IS SUBSTANTIALLY LIKELY TO PREVAIL ON THE MERITS

Plaintiff is substantially likely to succeed on the merits of her claim that Defendants' refusal to place her in an appropriate integrated community setting rather than isolating and segregating her in a mental hospital violates her rights under the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.

A. DEFENDANTS ARE VIOLATING THE ADA BY UNNECESSARILY SEGREGATING PLAINTIFF E.W. IN A STATE MENTAL HOSPITAL

1. The ADA: Its Background, History, and Purpose

The ADA is a major and comprehensive civil rights law designed to address this country's history of rampant discrimination against the disabled. The United States Congress recognized that discrimination against the disabled, often in the form of segregation and isolation, is a pervasive social problem. See 42 U.S.C. § 12101(a)(2).

Thus, after three years of debate and numerous hearings, the Congress passed legislation, which in the words of the House Judiciary Committee, " . . . promises a new future: a future of inclusion and integration, and the end of exclusion and segregation." 1990 U.S. Code Cong. and Admin. News 445, 449.

Title II of the ADA states that:

> . . . no qualified individual with a disability, shall by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. In passing this provision, Congress explicitly stated its purpose:

> To provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.

42 U.S.C. § 12101(b)(1).

The purpose of Title II of the ADA and its anti-discrimination provision was supported by strong congressional findings of wide-spread discrimination, segregation, and isolation of persons with disabilities with no legal recourse. Those findings were codified in the Act itself:

(a) Findings

The Congress finds that -

(2) 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;

(3) Discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education,

transportation, communication, recreation, institutionalization, health services, voting, and access to public services;

(4) . . . [I]ndividuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;

(5) Individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

(8) The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals . . . .

42 U.S.C. § 12101(a)(2), (3), (4), (5) and (8) (Emphasis added).

The legislative history resolves any doubt that could possibly remain regarding the purpose of the ADA to prohibit segregation and unnecessary institutionalization of the disabled. Numerous members of the House and Senate expressly stated their support for an end to segregation and isolation of the disabled through passage of the ADA.

For example, Senator Harkin, floor manager of the ADA in the Senate, stated that the ADA "guarantees individuals with disabilities the right to be integrated into the economic and social mainstream of society; segregation and isolation by others will no longer be tolerated." 135 Cong. Rec. 19803 (1989) (Emphasis added).

In a similar vein, Representative Collins stated that the "basic goal which runs through this landmark civil rights legislation . . . is to fully integrate disabled Americans into all aspects of life in our country." 136 Cong. Rec. 11430 (1990) (Emphasis added).

Congressman Miller recognized that "it has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality.

Society has made them invisible by shutting them away in segregated facilities." 136 Cong. Rec. 10877 (1990) (Emphasis added).

Senator Kennedy argued that the ADA would put an end to this unnecessary segregation: "the Americans with Disabilities Act will end this American apartheid. It will roll back the unthinking and unacceptable practices by which disabled Americans today are segregated, excluded, and fenced off from fair participation in our society." 135 Cong. Rec. 8514 (1989) (Emphasis added).

Last, and perhaps most eloquently, Senator Lowell Weicker, the original sponsor of the ADA and a former Chair of the Senate Subcommittee on the Handicapped, testified before that committee that the intent of the ADA was to end isolation, segregation, and discrimination:

> For years this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.

Americans with Disabilities Act: Hearing Before the Senate Comm. on Labor and Human Resources and Subcomm. on the Handicapped, 101st Cong., 1st Sess. 215 (1989) (Emphasis added).

The overwhelming legislative history, of which the above is a small sampling, coupled with the ADA's language and congressional findings would, in the words of Senator Harkin: "ensure once and for all that no Federal agency or judge will ever

misconstrue the congressional mandate to integrate people with disabilities into the mainstream." 135 Cong. Rec. S4985 (daily ed. May 9, 1989).

Senator Harkin's comment was addressing Congress' view that the federal agencies responsible for implementing Section 504 of the Rehabilitation Act of 1973 and many courts had frustrated the primary purpose of that Act, i.e., to end segregation of the disabled. The ADA was passed to cure this problem.[5]

2. The Integration Regulations Implementing the ADA

To provide even further insurance that the ADA would be properly construed and implemented to end segregation of the disabled, Congress required the Attorney General to issue regulations which "shall be consistent with [the ADA] and with the coordination regulations under part 41 of title 28, Code of Federal Regulations . . . applicable to recipients of federal financial assistance under section 794 of title 24 [Section 504 of the Rehabilitation Act of 1973]." 42 U.S.C. § 12134(b) (Emphasis added).

The Section 504 coordination regulations contain the "[g]eneral prohibitions against discrimination" with a specific requirement that "[r]ecipients [of federal financial assistance] shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d) (Emphasis added).

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[5]Section 504 of the Rehabilitation Act had been the law for seventeen years, yet, as stated by Representative Wolpe, "millions of Americans with disabilities are still subjected to widespread discrimination and segregation in all significant areas of their lives." 136 Cong. Rec. H2627 (daily ed. May 22, 1990). And Congress itself stated in its findings contained in the ADA that discrimination against the disabled, including isolation and segregation "continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2).

The Attorney General complied with the congressional command and enacted an ADA Title II integration regulation which provides that:

> A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130(d) (1995) (Emphasis added).

Thus, the Attorney General issued a regulation in which the failure to integrate is discrimination by itself. Significantly, this stand-alone requirement is unlike other Section 504 regulations in which the integration requirement is linked to differences in services provided to individuals with disabilities and those without disabilities. For example, the Department of Health and Human Services Section 504 regulations require integration only in the context of providing services for disabled individuals that are equal to services provided for individuals without disabilities. See 45 C.F.R. § 84.4(b)(2) (1993). The Section 504 coordination regulations do not require this linkage.

As noted above, Congress also required the Attorney General to issue Title II ADA regulations "consistent with" the rest of the ADA. The Attorney General's Title II regulation meets this requirement. For example, Title I of the ADA defines "discriminate" to include segregation of employees with disabilities. 42 U.S.C. § 12112(b)(1). Title III prohibits discrimination in the form of failing to provide services "in the most integrated setting appropriate to the needs of the individual." 42 U.S.C. § 12182(b)(1)(B). This Title III integration requirement is independent of and separate from other provisions in Title III prohibiting different treatment in providing services to disabled people compared to services provided to non-disabled people. 42 U.S.C. § 12182(b)(1)(A)(ii), (iii).

In summary, the Attorney General's Title II integration regulation is consistent with the ADA and the Section 504 coordination regulations as required by Congress. The failure to integrate the disabled is discrimination by itself. The Attorney General has advocated this position in other litigation, including Helen L. v. DiDario, 46 F.3d 325 (3rd Cir. 1995), cert. denied, 116 S. Ct. 64.

In mandating administration of services in "the most integrated setting," the Attorney General has described that setting as one "that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. Part 35, App. A at 454. According to the Attorney General, this requirement was "an important and overarching principle of the Americans with Disabilities Act. Separate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, integrated activities." Id. at 452. Thus, the Department of Justice summarized the meaning and intent of the ADA implementing regulations to prohibit exclusion and segregation:

> Taken together, these provisions are intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes of individuals with disabilities. Consistent with these standards, public entities are required to insure that their actions are based on facts applicable to individuals and not on assumptions as to what a class of individuals with disabilities can or cannot do.
>
> Integration is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second class status.

Id. at 451 (Emphasis added).

This commentary to the regulations is consistent with the report of the House Judiciary Committee which emphasized integrated services:

> As with Section 504 of the Rehabilitation Act, integrated services are essential to accomplishing the purposes of Title II. As stated by Judge Mansmann in ADAPT v. Skinner, "the goal [is to] eradicate the 'invisibility of the handicapped.'" . . . . Integration is fundamental to the purposes of the ADA.

H.R. Report No. 485, 101st Cong., 2nd Sess., pt. 3 at 50, 56 (Emphasis added).

As will be shown below, E.W. has been excluded, segregated, isolated, and discriminated against based upon her disability by the Defendants in violation of the express language of the ADA, the express language of the ADA's implementing regulations, and the express intent of the U.S. Congress summarized above.

3. E.W. Is a Qualified Individual With a Disability Within the Meaning of the ADA, Is the Victim of Discrimination by a Public Entity, and Has Been Discriminated Against Based Upon Her Disability

In order to prove a violation of Title II of the ADA, Plaintiff must demonstrate the existence of three elements: (1) that she is a "qualified individual with a disability"; (2) that she was the victim of discrimination by a public entity; (3) that such discrimination was by reason of a disability. See Concerned Parents to Save Dreher Park Center v. the City of West Palm Beach, 846 F. Supp. 986, 990 (S.D. Fla. 1994).

a. E.W. Is Clearly a Qualified Individual With a Disability

The ADA defines a disability as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record

of such impairment; or (C) is regarded as having such an impairment." 42 U.S.C. § 12102(2)(A)-(C). E.W. is mentally retarded and suffers from a personality change due to early childhood meningitis. She attended special schools throughout her childhood including Gracewood, a state institution for the mentally retarded. She has been in and out of mental institutions throughout her twenty-five years of adult life with over thirty admissions to GRH-A. She clearly suffers from disabilities that substantially interfere with major life activities. She also has a long record of suffering from these impairments and has long been regarded as suffering from such impairments. She is therefore an individual with a disability within the meaning of the Act.

E.W. is also a qualified individual under the ADA. Not only does she have a disability within the meaning of the Act, she qualifies for the community services which she seeks in this case. See Martin v. Voinovich, 840 F. Supp. 1175, 1191-92 (S. D. Ohio 1993). (Persons with mental retardation or developmental disabilities who could participate in a community residential services program were considered qualified for such services under the ADA.) The Defendants have admitted on numerous occasions, as documented in E.W.'s medical records and in the depositions of Dr. DeBacher, Dr. Patel, Charles Bliss, and Joseph Steed, that she needs or is suitable for a community placement outside the hospital. By Defendants own admissions, E.W. is qualified for community-based treatment. This view is also supported by Plaintiff's expert, Dr. Richard Elliott.

b. **Defendants Have Discriminated Against E.W. by Continuing to Institutionalize and Segregate Her in a Mental Hospital**

The text of the ADA, its legislative history, and its implementing regulations as already discussed above unequivocally establish a national mandate to end unnecessary segregation and institutionalization of persons like E.W. and to integrate such persons into society at large to the greatest extent possible. The Act, legislative history, and implementing regulations make equally clear that when Defendants fail to comply with this mandate, they commit discrimination.

Specifically, the ADA's implementing regulations require a public entity "to administer its services, programs and activities in the most integrated setting appropriate to the needs" of persons such as E.W. See 28 C.F.R. § 135.130(d) (Emphasis added). Here, the State of Georgia has undertaken to provide services and programs for the mentally retarded and mentally ill. Once it undertook to do so, it became obligated to provide those services in the most integrated setting appropriate to E.W.'s needs. The state's own doctors and treatment staff have admitted repeatedly that E.W. is eligible for placement outside an institution in a more integrated setting. Their failure to so place her violates 28 C.F.R. § 35.130(d) and the ADA.

Several court decisions have strongly affirmed the point that unnecessary segregation is discrimination per se. The best example is the recent case of Helen L. v. DiDario, 46 F.3d 325 (3rd Cir. 1995), cert. denied, 116 S. Ct. 64 (1995) which concluded:

> Thus, the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled. Accordingly, the district court erred in holding that the applicable provisions of the ADA 'may not be invoked unless there is first a finding of discrimination.'

Id. at 333.

Other decisions interpreting the ADA and its predecessor, § 504 of the Rehabilitation Act, have reached the same conclusion. See Halderman v. Pennhurst State Sch. and Hosp., 784 F. Supp. 215, 224 (E.D. Pa. 1992), aff'd, 977 F.2d 568 (3rd Cir. 1992) (Section 504 prohibits unnecessary segregation and requires reasonable accommodations to provide opportunities for integration); Coleman v. Zatechka, 824 F. Supp. 1360, 1373 (D. Neb. 1993) (in enacting the ADA, Congress "aimed to bring people with disabilities into society's mainstream, to cause the kinds of interaction which may facilitate recognition of the true equality of human worth as between individuals - regardless of disabilities."); Jackson v. Ft. Stanton Hospital and Training School, 757 F. Supp. 1243, 1299 (D. N.M. 1990), aff'd in part, rev'd in part, on other grounds, 964 F.2d 980 (10th Cir. 1992) ("Where reasonable accommodations in community programs can be made, Defendants' failure to integrate severely handicapped residents into community programs . . . violates Section 504"); Homeward Bound, Inc. v. Hissom Memorial Center, 1987 WL 27104 at *20 (N.D. Okla. July 24, 1987) ("Section 504 prohibits unnecessarily segregated services for retarded persons"); Ga. Association of Retarded Citizens v. McDaniel, 511 F. Supp. 126, 128 (N.D. Ga. 1981) (state school superintendent's refusal to consider needs of handicapped children violates § 504).

Violation of the ADA does not require any proof of intent to discriminate. As noted recently by the Third Circuit in the DiDario case:

> [b]ecause the ADA evolved from an attempt to remedy the effects of "benign neglect" resulting from the "invisibility" of the disabled, Congress could not have intended to limit the Act's protections and prohibitions to circumstances involving

> deliberate discrimination. Such discrimination results from "affirmative animus" which was not the focus of the ADA . . . . Rather, the ADA attempts to eliminate the effects of that "benign neglect", "apathy", and "indifference" . . . . [T]he ADA make[s] clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination.

46 F.3rd at 335 (Emphasis added). The language quoted by the DiDario court came from a Supreme Court decision construing the analogous Rehabilitation Act in which the Supreme Court noted that "[d]iscrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference - of benign neglect." Alexander v. Choate, 469 U.S. 287, 295, 105 S. Ct. 712, 717, 83 L. Ed. 2d 661 (1985); see also Concerned Parents, 846 F. Supp. at 991 ("Certainly intentional discrimination is banned by Title II. But further, actions that have the effect of discriminating against individuals with disabilities likewise violate the ADA." Emphasis in original.); Mayberry v. Von Valtier, 843 F. Supp. 1160, 1166 (E.D. Mich. 1994) ("Congress appears to have intended the ADA to address the discriminatory effects of benign action or inaction, as well as intentional discrimination.")

As noted above, the ADA prohibits only unnecessary segregation. Public entities may provide different services to persons with disabilities if "necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others." 28 C.F.R. § 35.130(b)(1)(iv) (1995) (Emphasis added). The Department of Justice, which promulgated this regulation, has indicated that this exception to the general rule of integration is a narrow one: "[s]eparate, special or different programs that are designed to provide a benefit to persons with disabilities

cannot be used to restrict the participation of persons with disabilities in general, integrated activities." 28 C.F.R. Part 35, App. A at 452. Furthermore, a person with a disability retains the right to participate in the regular program "despite [the] existence of permissibly separate or different programs." 28 C.F.R. § 35.130(b)(2) (1995).

Defendants have the burden of showing that separate or segregated services are necessary to provide effective services. The state can do this only after making an individualized determination of E.W.'s needs. 28 C.F.R. Part 35, App. A at 452. As the Department of Justice has noted, "[t]he starting point is to question whether the separate program is in fact necessary or appropriate for the individual." Id. (Emphasis added.)

The Defendants in this case cannot meet their burden. They have repeatedly acknowledged that E.W. no longer requires institutionalization and is eligible for a community placement. They have completely failed, however, to place her in a residential supervised setting with appropriate services. They have therefore discriminated against E.W. within the meaning of the ADA.

Finally, Plaintiff is not required to show that she has been denied access to services as a disabled person that are available to the nondisabled. In other words, simply because Plaintiff seeks access to services that are available only to persons with disabilities does not alter the analysis. The key is the plain language of the ADA which prohibits unnecessary segregation and isolation of individuals with disabilities. That alone constitutes discrimination.

Thus, courts have rejected the argument that discrimination occurs only if disabled persons are denied services that are available to the nondisabled. DiDario, 46 F.3rd at

335 (" . . . the ADA make[s] clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes, independent of the discrimination that arises when individuals with disabilities receive different services than those provided to individuals without disabilities."); Martin v. Voinovich, 840 F. Supp. at 1191-92.

In summary, by unnecessarily segregating and institutionalizing E.W., and failing to provide an appropriate community placement, Defendants have thereby discriminated against her within the meaning of the ADA.

c. Defendants Have Discriminated Against E.W. Based Upon Her Disability

Plaintiff has established that Defendants have discriminated against her under the ADA by unnecessarily excluding, segregating, and institutionalizing her. In order to prevail under the ADA, however, Plaintiff must also show that Defendants have excluded, segregated, and institutionalized her "by reason of [her] disability". 42 U.S.C. § 12132. Defendants have unquestionably done so.

E.W. is mentally retarded and suffers from a personality change due to a medical condition, meningitis. She has been institutionalized at GRH-A for these conditions during her most recent admission since February 1995. She has spent the better part of her adult life for the past twenty-five years in mental institutions or special placements. The GRH-A Treatment Unit, where E.W. currently resides, houses only persons with mental disabilities. Thus, E.W. has been placed at GRH-A "by reason of her disability."

Defendants may attempt to claim that they can keep Plaintiff at GRH-A or discharge her to a homeless shelter because they lack funds to place E.W. in a proper

community residential setting with the necessary treatment and services. Such an argument would be legally and factually insupportable.

First, such an argument would really be nothing more than an argument that Defendants have not intentionally discriminated against E.W. Plaintiff has already shown in Section II(A)(3)(b) of this brief, however, that the ADA does not require an intent to discriminate.

Second, continued institutionalization based upon lack of funds has already been rejected by the DiDario case in the face of an ADA claim. 46 F.3d at 338.

Third, just as in DiDario, a claim of lack of funds would be factually insupportable. The approximate cost of placing E.W. in an appropriate community residential setting ($39,000 to $72,000) would be substantially less than the amount spent each year to warehouse her at GRH-A ($84,000 to $184,000).

Fourth, in a similar context, the United States Supreme Court has held that cost considerations do not justify discriminatory conduct. International Union, UAW v. Johnson Controls, 499 U.S. 187, 210, 111 S. Ct. 1196, 1209, 113 L. Ed. 2d 158 (1991) ("The extra cost of employing members of one sex, however, does not provide an affirmative Title VII defense for a discriminatory refusal to hire members of that gender.")

It has also long been the law of this circuit that a state may not fail to provide treatment for budgetary reasons alone. Wyatt v. Aderholt, 503 F.2d 1305, 1315 (5th Cir. 1974) As noted in the Wyatt case, "'[H]umane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations,'" quoting Jackson v. Bishop, 404 F.2d 571, 580 (8th Cir. 1968). See also Concerned

Parents to Save Dreher Park Center v. City of West Palm Beach, 846 F. Supp at 993 ("The expenditure of funds cannot be considered a harm if the law requires it."); Kroll v. St. Charles County, 766 F. Supp. 744, 753 (E.D. Mo. 1991) (If county did not fund building improvements required under the ADA within two months, the Court would consider the imposition of a property tax increase, or an injunction of a rollback of local taxes to assure funding for the improvements).

In International Union, the Supreme Court particularly noted that Congress had considered the substantial cost of providing equal treatment under Title VII, but required equal treatment nonetheless. 111 S. Ct. at 1209. Similarly, Congress, in passing the ADA, also considered cost considerations. It acknowledged that the ADA might impose financial burdens on the states but felt that such potential costs were the price that had to be paid in order to eliminate discrimination against the disabled. As Senator Hatch stated, the ADA would:

> impose a lot of expenses and rightly so. It is time we did these things. It is time we brought persons with disabilities into full freedom, economic and otherwise, with other citizens in our society. This bill will do that. In doing so, we should be aware that it is going to be costly and difficult and that there will be some complaints.

135 Cong. Rec. 19835 (1989). Senator Harkin echoed this sentiment:

> [F]ocusing on the costs of compliance by covered entities was totally inappropriate given the economic benefits to society of reducing the deficit by getting people off of welfare, out of institutions, and on to the tax rolls.

135 Cong. Rec. 8508 (1989) (Emphasis added).

On the other hand, Congress strongly believed that discrimination had its own costs. As stated in the congressional findings incorporated into the ADA:

> the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and non-productivity.

42 U.S.C. § 12101(a)(9) (Emphasis added). In short, the disabled cannot be forced to endure the crushing weight of discrimination based upon mere cost considerations.

To summarize, E.W. is a qualified individual with a disability, is the victim of discrimination by a public entity, and has been discriminated against based upon her disability. She is therefore substantially likely to prevail on the merits of her claim under the ADA.

B. DEFENDANTS ARE VIOLATING THE ADA BY FAILING TO PROVIDE INTEGRATED COMMUNITY-BASED SERVICES AS A "REASONABLE MODIFICATION" UNDER THE ADA.

As already noted above, Defendants must administer their mental disability services in the most integrated setting appropriate to E.W. See 28 C.F.R. § 35.130(d)(1995). For E.W., that setting is a community-based residential setting. Defendants must also modify their programs to the extent that is required to avoid discriminating against the disabled:

> A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

28 C.F.R. § 35.130(b)(7) (Emphasis added).

Defendants cannot meet their burden of showing a fundamental alteration in this case. Defendants already have existing programs providing community services to persons such as E.W. The State of Georgia has established nineteen regional boards which oversee the provision of all disability services, including community services, to persons with mental disabilities. In fiscal year 1995, the state spent $96,834,822 on mental retardation community services, $112,025,305 on mental health community services, $80,940,807 on mental retardation institutional services, and $131,920,891 on mental health institutional services. (Defendant Olmstead's Answers to Plaintiffs' Interrog. Nos. 2-9, Exh. 18).

Moreover, Dr. Richard Elliott has identified several potential providers for E.W. including TOPS (Tailored Options For Person-Centered Support), which has indicated that it could serve E.W. if funds were made available. (Elliott aff. at ¶¶ 14 and 15, Exhibit 1; Elliott dep. at 29, l. 6-10; 77, l. 14-24, Exhibit 5).

With existing programs and established funding for providing services to persons such as E.W., Defendants cannot demonstrate that any fundamental alteration of their program is required in order to serve E.W. appropriately in the community. In a similar context, the Third Circuit has already ruled that providing community-based services does not require a fundamental alteration within the meaning of the ADA. See DiDario, 46 F.3rd at 337-38; see also Martin v. Voinovich, 840 F. Supp. at 1190-91.

III. PLAINTIFF E.W. FACES A SUBSTANTIAL THREAT OF IRREPARABLE INJURY IF THE PRELIMINARY INJUNCTION IS NOT GRANTED

Plaintiff has suffered over thirty hospitalizations on a locked psychiatric ward at GRH-A. She has spent a considerable part of twenty-five years of adult life at the Treatment Unit of GRH-A even though Dr. DeBacher has noted that the Treatment Unit at GRH-A "was never intended for long-term habilitation" and "is unavoidably lacking as a long-term growth environment." (DeBacher eval. of E.W. at 6, ¶ 4, Exh. 12). As a result, E.W. has quite predictably "become so worn out in this environment that she would benefit from a complete change of scene to help her climb out of her depression and take a renewed interest in life." (Id.)

Dr. DeBacher's evaluation is consistent with the evaluation of the behavioral consultant for the Defendant Fulton County Regional Board who has stated that E.W. is deteriorating over time. (Steed dep. at 70, l. 22-24, Exh. 4).

Dr. DeBacher's evaluation is also consistent with Dr. Richard Elliott's evaluation which concluded that:

> E.W.'s continued hospitalization at GRH-A has and will continue to have a negative impact on her treatment and habilitation because it is likely to contribute to her depression, dependence, and lack of motivation and because what E.W. needs, more than any other single component in her treatment, is an opportunity to learn how to develop and enhance her existing abilities in a community, rather than institutional, context.

(Elliott aff. at ¶ 12, Exh. 1).

E.W.'s history and present circumstances demonstrate that her condition will continue to deteriorate if she is not integrated into the community with adequate services.

The endless cycle of discharges and re-hospitalizations will continue until E.W. reaches the point of no return - permanent institutionalization. This is the very result that the ADA was designed to prevent.

The law is well-established in this Circuit that an injury is irreparable if it cannot be remedied by monetary damages. Cate v. Oldham, 707 F.2d 1176, 1189 (11th Cir. 1983). The continued negative impact that institutionalization at GRH-A is having on E.W. cannot be compensated by monetary damages. In at least one other identical context, another court has so held. Daniel B. v. White, No. Civ. 79-4088, 1991 WL 58494 at *3 (E.D. Pa. 1991).

In Daniel B., the court specifically found that "continued institutionalization of the class members, even for a short time, will cause irreparable harm." Id. The court so found because the evidence showed that confinement had impeded the class members' development and caused them to regress. Id.

Just as in Daniel B., the evidence in this case shows that E.W.'s condition has deteriorated while at GRH-A and will continue to deteriorate so long as she remains there. The harm caused to E.W. by her inappropriate institutionalization is immeasurable, potentially irreversible, and not compensable in monetary damages.

In another case specifically involving the ADA, a court found that a group of disabled citizens suffered irreparable harm when a city attempted to eliminate city recreational programs for the disabled. Concerned Parents to Save Dreher Park Center, 846 F. Supp. at 992. The court so ruled because the disabled would have a more difficult time creating their own recreational opportunities and because "[t]hese programs,

prior to their elimination, were contributing to a sense of emotional and psychological well-being" that monetary damages could never remedy. Id.

E.W.'s "emotional and psychological well-being" has obviously been harmed during her confinement at GRH-A. She has suffered and will continue to suffer irreparable harm so long as she is unnecessarily confined to a locked psychiatric ward and so long as Defendants refuse to provide her with an integrated community placement with appropriate services.

IV. THE THREATENED HARM TO PLAINTIFF OUTWEIGHS THE POTENTIAL HARM TO THE DEFENDANTS

The threatened harm to E.W. caused by Defendants' refusal to place her in an appropriate community placement far outweighs any harm the requested injunction may have on the Defendants. Defendants can show no special harm by integrating E.W. into the community. In fact, E.W.'s integration into the community would cost less than her forced confinement on a mental ward.

On the other hand, E.W.'s isolation and segregation at GRH-A is causing her condition to deteriorate, dimming any remaining hope that she will ever be able to live more freely, more independently, and more productively in society. Without the requested injunction, E.W. will continue to suffer irreparable injury.

V. THE REQUESTED INJUNCTION IS IN THE PUBLIC INTEREST

Granting the requested injunction in this case will promote the public interest.

First, the U.S. Congress has unequivocally found, through passage of the ADA, that the public interest is served when the disabled are fully integrated into society rather

than shut away in institutions. Integration is precisely what Plaintiff E.W. seeks in this case.

Second, many states have expressed their view that integrating the disabled into society is in the public interest. For example, many states have closed the great majority of their public psychiatric and mental retardation beds and reallocated funds to community-based services.

Third, the Georgia General Assembly recently gave a strong commitment to the need for community services for the mentally disabled in the State of Georgia by passing H.B. 100, O.C.G.A. § 37-2-1 et seq. That Act specifically recognized the state's obligation to meet the needs of the mentally disabled "through a coordinated system of community facilities, programs, and services." O.C.G.A. § 37-2-1(a). Most importantly, the Act created a new Division of the Department of Human Resources, the Division of Mental Health, Mental Retardation, and Substance Abuse, and gave the Division the unprecedented power to move funds from institutional services to community services. O.C.G.A. § 37-2-5.2(c)(3).

Fourth, the public interest is best served when discriminatory actions, particularly ones based upon archaic attitudes and "pernicious mythologies," are restrained. See, e.g., Baxter v. City of Belleville, 720 F. Supp. 720, 734 (S.D. Ill. 1989).

Finally, the public interest is not served when, with respect to E.W. in particular,

> . . . each day that she remains at GRH-A is a day lost forever that could provide her with the opportunity to learn, to work, to experience life in a reasonably normal, supportive environment, to interact with non-disabled individuals, to make daily choices, and to become a more independent and productive member of society. . .

Elliott aff. at ¶ 16, Exh. 1.

It is time that these Defendants be ordered to conform their actions in accordance with the over-riding public interest calling for integration of the disabled into society.

CONCLUSION

For all of the foregoing reasons, Plaintiff E.W. respectfully requests that her Motion be granted.

This 12th day of July, 1996.

Respectfully submitted,

Susan C. Jamieson (by stac w/ express permission)
SUSAN C. JAMIESON
Georgia State Bar No. 389408

CHARLES BLISS
Georgia State Bar No. 063385

340 W. Ponce de Leon Avenue
Decatur, Georgia 30030
(404) 377-0701

Steven D. Caley
STEVEN D. CALEY
Georgia State Bar No. 102866

SYLVIA B. CALEY
Georgia Bar No. 611240

151 Spring Street
Atlanta, Georgia 30303-2097
(404) 614-3926

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I certify that Defendants in the above-styled action have been served a copy of the Motion for Preliminary Injunction and Brief in Support thereof by placing a copy of same in a properly addressed envelope with adequate postage thereon for delivery by first class mail to the individual listed below:

Ms. Patricia Downing
Sr. Assistant Attorney General
40 Capitol Square
Atlanta, Georgia 30334

This the 12th day of July, 1996.

Steven D. Caley
STEVEN D. CALEY

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

L.C., by JONATHAN ZIMRING as guardian ad litem and next friend, Plaintiff, v. TOMMY OLMSTEAD, Commissioner of the Department of Human Resources; RICHARD FIELDS, Superintendent of Georgia Regional Hospital at Atlanta; and ERNESTINE PITTMAN, Executive Director of the Fulton County Regional Board, all in their official capacities, Defendants.	CIVIL ACTION FILE NO. 1: 95-CV-1210 MHS

AFFIDAVIT OF RICHARD L. ELLIOTT, M.D., PH.D.

Personally appeared before me, the undersigned officer authorized to administer oaths, Richard L. Elliott, M.D., Ph.D., who, after being duly sworn, states:

1.

My name is Richard L. Elliott, and I am more than 18 years of age. I suffer from no legal disability, and am competent to testify to the matters set forth herein.

2.

This affidavit is made upon my personal knowledge of the matters set forth herein and based on my professional judgment and opinion.

3.

I am the Program Director and a Professor in the Department of Psychiatry and Behavioral Science and the Director of the Center

EXHIBIT 1 (6p)

for Public Mental Health Advocacy at Mercer University School of Medicine, Macon, Georgia.

4.

The Curriculum Vitae attached to this affidavit contains accurate information regarding my educational and professional background and publications.

5.

I have evaluated the Plaintiffs, L.C. and E.W., at the request of their attorneys and the results of both evaluations have been summarized in reports which have been filed with the court. This affidavit is related to my evaluation of E.W. and, particularly, whether her needs could be met in an appropriate community setting.

6.

In my assessment of E.W., I reviewed extensive hospital records, several previous psychological evaluations, and spoke with staff from a community-based service provider who were present when I met with E.W. on February 22, 1996, and with E.W.'s mother. I have also reviewed the depositions of E.W.'s treating physician, Dr. Patel, at Georgia Regional Hospital at Atlanta (GRH-A) and a staff psychologist at the hospital, Gary DeBacher, Ph.D., who assessed E.W. for the apparent purpose of providing his opinions and recommendations to E.W.'s treatment staff.

7.

The community service provider that came to the hospital to meet with E.W. and to be present during my interview with her calls itself TOPS (Tailored Options for Person-Centered Support); the director, Michael C. Biggs and a member of his staff, Toni Dozier,

were both present at the request of the patient's attorney and mother, because I wished to have an understanding of the feasibility of serving E.W. in the community.

8.

It is my understanding that TOPS is one of several providers of community-based services to persons with mental disabilities; these providers receive most of their funding for these services through the publicly-funded Regional Boards, such as the Fulton County Regional Board.

9.

In conducting my evaluation of Plaintiff, L.C., in addition to my review of documents, interviews, and other activities, I also visited the community-based residential program, NYASHA HANDS, where she presently resides and spoke with several members of the staff who operate that program and are involved in the implementation of L.C.'s community service plan. As my report on L.C. indicates, this residential program, in conjunction with other community service providers, is meeting L.C.'s needs as a mentally retarded and mentally ill adult with a history of behavior problems.

10.

Based on my assessment of E.W., including the information received from the above-mentioned community service providers as well as my own knowledge and experience with the provision of community services to mentally disabled adults, I was able to form a professional opinion about whether E.W. could be placed in a more appropriate, integrated community setting. This opinion is set

forth in more detail in the following paragraphs.

11.

E.W.'s needs could definitely be met in a community placement with adequate supports, including staff trained in crisis intervention, behavioral techniques, and other habilitation services.

12.

E.W.'s continued hospitalization at GRH-A has and will continue to have a negative impact on her treatment and habilitation because it is likely to contribute to her depression, dependence, and lack of motivation and because what E.W. needs, more than any other single component in her treatment, is an opportunity to learn how to develop and enhance her existing abilities in a community, rather than institutional, context.

13.

E.W.'s history of more than 30 psychiatric hospitalizations since 1975 indicates clearly that her limitations due to mental retardation and her behavior problems require a more structured, community residential program with staff experienced in mental retardation and more individualized supports than previous placements have provided.

14.

During my interview of E.W., TOPS staff indicated that they were able to assess E.W.'s ability to live in the community, that she would not be an especially difficult person to serve, and that she presented no current symptoms or functional disturbances which would prevent TOPS from accepting E.W. into their residential

program, if they had the necessary funding to provide the needed services.

15.

In concluding that a program such as TOPS or NYASHA HANDS could serve E.W. in the community, I am specifically referring to the capacity of these or similar programs, with adequate funding, to provide or arrange for the following:

1. comprehensive multi-disciplinary assessments;
2. transportation to and from medical psychiatric appointments;
3. regular medical care with special attention to weight control and to E.W.'s urinary incontinence;
4. frequent monitoring of any prescribed psychotropic drugs and ongoing assessments to determine whether psychotropic drugs are indicated;
5. vocational and leisure programs;
6. continuing day habilitation in a structured setting;
7. crisis management;
8. psychiatric oversight;
9. behavioral monitoring and interventions as indicated; and
10. contact with family in a supportive environment.

16.

Since there is no current need for the institutional placement of E.W., each day that she remains at GRH-A is a day lost forever that could provide her with the opportunity to learn, to work, to experience life in a reasonably normal, supportive environment, to make basic daily choices, and to become a more independent and

productive member of society.

Further the affiant saith not.

This 10 day of July, 1996.

Richard L. Elliott

RICHARD L. ELLIOTT, M.D., PH.D.

Sworn to and subscribed
before me this 10
day of July, 1996.

Eduardo Mesa

NOTARY PUBLIC

treatment plan that you're talking about?

A Yes.

Q All right now, at that point, did you again feel she was appropriate for discharge?

A At that point, I think I did not have any ground to hold her against her wish in the hospital if she don't want to participate in the treatment. She's a voluntary patient.

Q You have the ability to have people involuntarily confined if you think that's appropriate; is that correct?

A Involuntary?

Q You can initiate procedures to have them involuntarily confined if you feel that's appropriate.

A If I feel that she meets the criteria for involuntary hospital admission.

Q Did you feel at that point that she met the criteria?

A No, I did not.

Q What are the criteria for involuntary hospitalization?

A Eminent danger to self or others due to mental illness.

Q So at that point, you decided to

EXHIBIT 2 (8.)

discharge her to another -- well, I guess a homeless shelter or personal care home. What was it?

A Shelter, homeless.

MR. BLISS: Okay. Let me just get another exhibit marked.

BY MR. BLISS:

Q Looking at what's been marked as Exhibit 2, Dr. Patel, what is that?

A It's a three-page document of a progress note copied out of the patient's chart.

Q Okay.

A I'm sorry. It's a four-page document.

Q Okay. And I just want you to look at the middle of the second page, right at the end of the part that you wrote. I believe this first thing, MD's note, that's a note that you wrote.

A Yes.

Q It is note that you wrote?

A Uh-huh. (Affirmative.)

Q Okay. At the end of that note, it says patient is not in any crisis at this time. Will discharge patient to shelter; is that correct?

A Yes.

Q Okay, what did you mean that she didn't have any crisis at that time?

whatever you testified she said -- would she have been appropriate to discharge to a personal care home at that time?

A If she's not asking for the discharge, no.

Q Why not?

A Because she wants help to change her behavior. And if that can be allowed, no doubt, I mean, that she could be discharged; she could be treated as an outpatient; but she's asking to be treated in the hospital.

Q Right.

A I don't see any reason not to keep her in the hospital.

Q So based on her choice then, she's appropriate to maintain in the hospital. You also felt that she could have been treated as an outpatient at that point?

A Yes. Personality disorder per se does not require hospitalization because that's a changed long-term pattern of behavior, unless there are crisis.

Q What sort of crisis would necessitate hospital treatment?

A Well, borderline patients do become

suicidal; do become homicidal at times. They do express -- they do become psycotic at times. And those are symptoms that require them to be stabilized with medication, and that's the time that you put them into the hospital.

Q What sort of treatment would have been appropriate for her in the community at this time? Assuming she had chosen to be treated in the community, what sort of treatment would that have required?

A What sort of treatment?

Q Yeah, what sort of treatment and what sort of placement would that have required?

A Same kind of treatment that she would require for change of her behavior in the hospital.

Q And what kind of -- what kind of treatment was that?

A Outpatient mental health follow up.

Q Are their providers capable of providing that treatment to her in the community?

A Majority of the personality disorders are treated in the community.

Q Okay. Since she elected to stay in the hospital or since at some point -- well, why -- what happened to change her mind that she stayed in

do you feel EW could be treated in the community at this point still?

A She has difficulty with physical problems at this time. And if that is addressed, I think she could be treated in the community.

Q Those physical problems, they could be addressed -- I guess she's catheterized -- she's catheterized four times a day; is that correct?

A Up to four times a day, preferably.

Q A visiting nurse could do that, couldn't they?

A Yes.

Q Okay. Sometime after this March series of events, there was a staffing concerning EW in April, I believe.

A Yes.

Q Do you recall that?

A Yes.

Q What happened at that staffing?

A Well, I think we discussed the problem issue and concerns from our PNN at that point, also the difficulty with the placement.

Q Uh-huh. (Affirmative.)

A And any treatment issues that were raised. One of the concerns was raised about the

A No, I haven't talked to her about that.

Q Has anyone else, to your knowledge?

A I really don't know.

Q Have you explored any placement options with EW or have you discussed any placement options with her other than personal care homes?

A No, I have not.

Q She has these behavioral problems, and I think that's one of the things that was noted on the master treatment plan was the long-term institutionalization. Would you agree that it's better to address those problems in the community than in the hospital?

A It's a long-term problem. It could be addressed in community. But I don't know whether you can call it addressed better in community. No, I think it can be fully good addressed in either outpatient or inpatient. Preferably, from the cost containment point of view, I think it could be addressed better in the community.

Q It would be cheeper to address in the community?

A I don't expect it to be cheeper. It's probably come out to be same in that sense. But from

the point of view, they want all the patients to be treated as outpatient.

Q Okay. Has it -- one of the things that you indicated was that she would need a transition between the hospital and an outpatient treatment or residential placement.

A Any place that she would go.

Q Okay. In her earlier discharges, was there any transition when she went to the personal care homes, say in January and February?

A That was the time that we would want to try outpatient going in there and seeing how she would stay there and live there.

Q All right. So it's not an involved process of doing a lot of stuff to do the transfer. You just take her there and see if it works out and monitor her closely for a while. Is that the sort of transition you're talking about?

A Yes.

Q So in fact, there were transitions before. You were going to monitor her in those personal care home placements and see how she was doing?

A That's correct.

Q If you were aware of a provider who

could meet -- who could meet her needs in the community, would you be in favor of placing her in the community?

A Yes; why not?

MR. BLISS: Okay. I don't think I have any further questions for you, Dr. Patel. Let me just talk to Sue for a second.

(A discussion was had off the record.)

MR. BLISS: All right, I think that's all we need to do. Thank you.

(The deposition concluded at 12:25 p.m.)

Q Why?

A In order to use the Medicaid waiver we would be required to permanently close down a bed. We cannot permanently close down a bed when a client leaves. We have to then continue to use it in the treatment of the next client that comes to our door. Therefore, Medicaid waiver is not an option for us at this point.

Q What do you base that opinion on?

A I knew you were going to ask me that.

Q You did?

A As best we could understand it from Elaine King when we asked that specific question.

Q That's what you based the opinion you just expressed on?

A Yes.

Q Elaine King's position?

A What is her position?

Q No. You based your view that you just described on what Elaine King told you?

A Yes, correct.

Q And you still are of that opinion?

A Yes.

Q So in all the years you've been on this unit, you've never felt you could explore Medicaid

antipsychotic medication?

A I don't. I mean, I don't treat anything with medication.

Q I understand that. But in your familiarity with E.W.'s case is that how this behavior was addressed in March? Do you know?

A I don't know.

Q Why would she, in your opinion, think in March or recently that she's leaving the hospital?

A Well, I indicated that that was simply one of the issues. The other issue of course is the separation from her mother.

Q Is something happening in that area recently?

A Her mother is expressing much frustration with E.W. and the situation and, yes, is more verbal, I believe, with E.W. about how she's feeling.

Q Charley, do you think E.W. needs to be in this hospital? I mean, the reason I ask is it doesn't look, in my opinion, which is not much value, that things are getting any better for her. And she's been here a year and a half.

THE WITNESS: Is it okay? Can I answer just my opinion?

MS. DOWNING: Well, I was going to

EXHIBIT 3 (4p)

object to the form of the question to the extent that it's asking for anything other than his professional opinion, which is really the only thing that he can state. To the extent that you're professionally competent to have an opinion, then you can state that.

THE WITNESS: When E.W. is not experiencing a moment of crisis, a time of crisis, I do not feel that she needs to be in the hospital. When she is in a period of a crisis, I do believe she needs hospitalization.

BY MS. JAMIESON:

Q Are you familiar with ways to manage crisis in a nonhospital setting?

A Again, my primary prospective is from hospital.

Q And again, I'm not asking for a professional opinion there. I just wanted to know if you know from your years of working in mental health of mechanisms for handling methods of crisis management in a community setting.

A Yes. There are methods of de-escalation.

Q Do you have a professional opinion whether

discharge of her to a shelter?

A Yes.

Q You have a recollection of that?

A Yes.

Q I'm just going to ask you whether you have an opinion about whether that would have been an appropriate discharge?

A I would have had concern that she would have returned to the hospital promptly.

Q Do you know from your familiarity with her records or her hospitalizations that she has in fact been hospitalized many times?

A Yes.

Q And do you know whether those placements have been primarily, if not exclusively, in personal care homes in the metro Atlanta area?

A I believe so, yes.

Q Do you have an opinion about whether the placement of E.W. in a personal care home is appropriate?

MS. DOWNING: Could you read the question again?

(The previous question was read back by the court reporter.)

MS. DOWNING: And again, the form of

saying although E W has said she needs to be let out, her records speak differently. One who has been placed in a hospital 46 times in the past nine years clearly is having problems functioning. The fact that she herself has stated that she can't make it in society only adds to this notion. This is not to say that she couldn't make it someday. Given the correct treatment options, she could function quite well in a group home. An effective treatment plan would need the following options at least as a minimum: A placement location focusing on the treatment of mental illnesses instead of mental retardation. This is most likely one of the reasons why E W is currently in the state she is; 24-hour supervision; regular medication checks; a strict program of behavior management focusing on controlling her aggressive behaviors; and some type of psychological assistance, preferably intensive, to get at the root of many of these behaviors.

Q So what you're saying is that if you could find a group home that provided those types of treatment, she would be okay for placement in the community?

A Yes.

Q Are you aware of group homes that

EXHIBIT 4 (5p.)

group home; is that correct?

A Right, if the right people are there.

Q Then you say some type of psychological assistance, preferably intensive, to get to the root of many of these behaviors. What do you mean by that?

A Well, it was -- from reading the reports in the records and also talking with some of the staff, it was their belief that basically E W has had not the best home environment. You know, her mother has been placed in jail before for dealing drugs; there were possible allegations that her father sexually abused her.

And in my experience, a lot of those behaviors that occur early on in childhood can all -- can of course cause difficulties later this life. And it was my observation that a lot of those behaviors have not been discussed or gone into a lot of detail with E W. And that if she goes to a home that that could be done, then maybe some of these aggressive behaviors would -- you know, would calm down some.

Q So that kind of psychological assistance could be provided in a community setting as well?

A Right; that's something that usually would need to be done either -- in some aspects -- either going to an outpatient hospital and having regular visits with a counselor or psychologist, something like that.

Q Okay. Going back to the report, on page 2 --

A Uh-huh. (Affirmative.)

Q -- you say it appears that E W receives little or no psychological assistance for these behaviors on a continuing basis. What do you mean by that?

A What I mean by that, from looking at some of the records and just going by some observations also, it appears that while she's been in the hospital whenever she's gone in, she's gotten some assistance or she's had her medications taken care of; but apparently, it seems whenever she's left the hospital and gone back to her group home -- whichever one it's been -- that's when problems typically start again because there's not a lot of continuation there as far as a regular schedule of getting counselling, getting medication.

Q Are you aware of where her placements have been when she's been placed out of the hospital?

somewhere every time. Because from her diagnosis, I could see that being a problem if she was having to be moved somewhere every time to go get assistance.

Q What about her diagnosis; would it make that a problem?

A Well, the fact that she does have paranoid behaviors, she might be resistant and thinking that somebody is trying to take her away every time. The fact that she's leaving a familiar location might cause some anxiety, whereas -- I know, too, for example, some hospitals, a lot of times when they see a psychiatrist or counselor, some hospitals in particular have a history that you don't see the same person every time.

Sometimes you might see a different doctor so there's no chance for E W to become familiar with the person and build some rapport; whereas if a person came to her place where she already feels comfortable and relaxed, and it's the same person, she will be able to build some rapport and trust.

Q All right. Is it your impression that she's deteriorating over time?

A Yes.

Q And what do you base that on?

Q Do you know of an occasion in which they held her down and tried to pray the demons out of her in a personal care home?

A No.

Q Okay. Again, might that contribute to her sense that the people were out to get her?

A If it happened, it might.

Q Now, do you think it would ever be appropriate to discharge her to a homeless shelter, to discharge E W to a homeless shelter?

A No.

Q Did you look at her records back to say any time during this, would it have been inappropriate to discharge her to a homeless shelter?

A Do I think it would have been inappropriate to discharge her to a homeless shelter? Yes.

Q Now, what was the reason for her last admission to the hospital?

A As far as what I have here, the reason she was being considered for admission -- this is from a report out of the file you had; it was on 1/20/94 -- is that in the one section here, they said the patient was being considered for admission based on suicidal and homicidal ideas and gestures; and

interview stated in your report?

A Yes.

Q Is there anything else you recall at this point that's important about that interview?

A No.

Q At that point, did Mr. Biggs express an opinion -- I believe you did state in your report he had stated an opinion about whether she could be provided services and the opinion was that she could.

A Yes.

Q And in your report, the part that reflects your review of the records and the interview is the past psychiatric history and the middle staff examination. Is that accurate?

A I'm sorry. Could you say that again?

Q Yes. As far as the part of your report that actually reflects your interview and your review of the records that day, is that stated in the history portion and the mental status examination primarily?

A Yes.

Q If we could kind of wrap up this part about the document review, did you review any documents other than what we've already talked about today and your interview, which is, the best you can recall, the psychological reports that were sent to you prior to the interview, the records at the

think a little different about what would be minimally adequate.

Q And you also used the term habilitation.

A Yes.

Q Define habilitation as you're using it in your report.

A Well, habilitation consists of those services, usually training, education that develop a person's capacity or to develop their capacities, their functioning ability. It's distinguished from rehabilitation which are those services, usually training and education and other supports that help people to re-acquire previously learned skills and re-acquire previous capacities.

Q So then could you use the word habilitation to apply to something other than an MR patient, as you're defining it or do you consider it to be --

A Conceivably, conceivably, sure.

Q But generally do you use the word habilitation to define services for MR patients?

A It arises most often in the context of people who are mentally retarded.

Q As you use the term minimally adequate, are there states other than Georgia that generally provide what you would call minimally adequate treatment to patients such as E. W.?

country and that's what I'm asking about.

Q (By Ms. Downing) What programs are those that you talked about?

A (The Witness) Well, for example, I could give you names of some other programs, but the best way of answering that is to say that there are literature reviews of programs which provide these services and the literature reviews will list individual programs, but they give a composite picture about the success of each program. So, it's based on more than one program. It's based on many programs and the results are generalizable across programs.

Q Are there any others that you --

A Well, the Vineland model, I think is a name that people are familiar with. V-I-N-E-L-A-N-D.

Q Is that a particular program?

A It's a model and there are many people around the country that have used something like the Vineland model to care for people with developmental disabilities in communities.

Q Any others?

A Any others? Gosh, off the top of my head I wouldn't want to -- no, I can't think of any others off the top of my head.

Q Let me go back to the PACT program. No, let me go back to the Rock County Health Program that you mentioned.

At that point, nobody had been returned to the hospital. So, that's an example of a program that took people with far more serious disabilities than E. W. and were very successful in getting a people a chance at living in the community.

Q Who was the director, by the way, that you called?

A I don't remember.

Q I was just curious since you remembered the phone call.

A I remembered the phone call because when I was writing up the article, I was curious about what had happened. That's where I developed it.

Q This is one you've written an article about?

A Right. I wrote about a couple of the people. It was sort of an ethical decision what might happen.

Q Which article was it?

A That was the Lithium.

Q The Lithium article?

A Right.

Q What about the PACT program, what is that? Is that a particular program or is that a model?

A It's now a model. Originally, it was a particular program.

Q And when it was a particular program, what was it?

A It was the Program on Assertive Community Treatment and before that it was called training in community living.

And originally it was a hospital-based program, I think still has some hospital bases. The notion is to provide whatever supports are necessary to help people live in the community, whatever support, whether it's cooking, cleaning, work, food, medicines, whatever it is.

Q Then you mentioned the Vineland model, but those are the only program, per se, you've mentioned. Is that right?

A When you say programs, specifically what kind of programs are you thinking about?

Q I was following up again on your comment that there were many programs in the country that could provide minimally adequate treatment.

A Oh, yes. Okay.

Q Were there any others that I overlooked that you mentioned?

A Well, when I was with the state -- and I don't remember the names of these programs, but I had occasion to work with a handful of programs even in the Atlanta area that seemed to care for people with severe disability, sometimes severe head trauma, mental retardation, severe and persistent mental illness. And there were several of these programs, even in Atlanta, that seemed to have a pretty good track record. I can't remember the names of these programs off the top of my head.

Q What do you remember about them that would help us

A No.

Q And then you also said she didn't have the benefit of certain medication trials and those are listed in your report.

A She's been tried on several different medications but the field is such that there are a good many trials that have been conducted with medications that, given the number of times she's been in the hospital, the number of years she's been in the system, she should have had a trial of some of these other medications to help her with some of these behaviors.

Q Is it possible that she did, but you just don't have the records for those?

A It's possible. I did ask her mother about some of her past treatment histories and it didn't sound like she had trials of some of these. I believe she had not had much exposure to vocational rehabilitation. She had started a behavior treatment plan and some vocational rehab in the several months prior to my evaluation. Given the number of hospitalizations and the length of the current hospitalization, it didn't appear to have been a thoughtful, planned, systematic approach to her habilitation and care. It had been poorly implemented, at least the behavioral plan. It doesn't appear to have been put together with good baseline data and good monitoring. I believe with the discharge plan

last year that led to the staffing in April of '95, the plan to discharge her to a shelter reflected a less than minimally adequate degree of planning and concern for her needs.

Q Is there anything else that was not -- was less than minimally adequate?

A I could go on. Dr. Patel's conclusion that what she needed in the community was referral to a community mental health center for treatment of her personality disorder reflects an inadequate understanding of her needs and here I'm referring to a statement on page 26 of his deposition. The question was what sort of treatment would have been appropriate for her in the community at this time? Assuming she had chosen to be treated in the community, what sort of treatment would that have required? His response was, what sort of treatment? Question, Yeah, what sort of treatment and what sort of placement would that have required? Answer, Same kind of treatment that she would require for change of her behavior in the hospital. Question, And what kind of -- what kind of treatment was that? Answer, Out-patient mental health follow up. That's an example that I think is consistent with the treatment she had received in the hospital most of the time. That put her generically into some sort of mental health group without any recognition of her specific needs and without any recognition, and this was shocking to me, of the multiple hospitalizations, the failure of treatment plan and

to generically speak of her as needing referral to out-patient mental health treatment, I think once again would doom her to failure and that's not minimally adequate.

Q Was there anything else in the not minimally adequate part of your report?

A Without being redundant, I think that covers a lot of ground.

Q All right. Now, let me back up on the diagnosis part. In your opinion is the diagnosis that Dr. Patel gave her, was that less than a minimally adequate diagnosis?

A In two ways. First, again, and this is the less severe of the two criticisms. I think it was wrong to label her as having a borderline personality disorder for the reasons we discussed earlier.

Q Because of the pejorative aspect of it?

A Well, it was wrong because she has a -- if you want to label her as having a personality disorder, if you're doing this for research purposes, she would have a personality change due to a general medical condition, meningitis. But that's not the severe criticism. The severe criticism is that even if she had a borderline personality disorder -- if she did have that, then the treatment plan is pretty much all wrong. Long hospitalizations, frequent hospitalizations are the wrong kind of treatment for somebody with a borderline personality disorder or with whatever you want to call the

the way to go. Regional boards, if they had flexibility -- if they could use their money the way they wanted to use it and weren't line itemed to sending it over to state hospitals, they could develop programs like that. It wouldn't cost any more. People would be happier. That's the kind of vision that I think was behind House Bill 100.

Q Okay. I'm just about to wrap up here. Okay. I had to ask this. This is switching gears here. What is the Dow of Pooh?

A I am delighted in your interest. It was a tongue-in-cheek book review I did for a Christmas issue of the American Journal of Psychiatry.

Q And was there a book called The Dow of Pooh?

A Yes. You are leaving no stones unturned.

Q Well, not that particular stone. I think there are probably some other stones in here.

A No poohs undowed.

Q Give me just a minute to review my notes and that ought to wrap it up. You said you don't know the amount of time you billed to date. Do you know the amount of money you've billed to date on this case, up until this deposition?

A I won't bill any more than fifteen hundred dollars.

Q You have a cap?

A Self-imposed cap. I'll have to add it up, but it won't be any more than that.

Q When you say you contact the county of residence, what organization within the county is it you contact?

A The developmental services office for the various counties, for instance, the DeKalb MR service unit or the Fulton MR service unit.

Q And then you said I think at the end the placement often doesn't materialize. What sort of problems do you have?

A Resources are usually our major problem.

Q There aren't enough placements for your people?

A Monies available for the placements.

Q The placements are there; there's not the money to fund them? Is that a problem?

A Right.

Q Let me back up a little bit. What sort of level of retardation do you have on the DLC? What sort of people are you placing?

A We place all of those, profound, severe, mild, and moderate.

Q Do you have people there who have additional problems? Do you have people who have problems with aggression?

A We do in our unit.

EXHIBIT 6 (4 p.)

selecting the person it best sees as meeting their needs.

Q So again, it was a matter of getting the dollars?

A (Witness nods head affirmatively.)

Q Once you have the dollars, you can find a place?

A You can be able to count on it.

Q Do you have people waiting on the DLC now, essentially waiting for money to be freed up to be placed in the community?

A Yes.

Q How many would you estimate?

A Approximately, conceivably, even though it's not a dismissed petition, conceivably half of our population.

Q Okay. You said even though it's not in the petition. I didn't understand a couple of words of what you said.

A A dismissed petition. A person in our program has to be committed through a formal court process with a petition for continued habilitation. So when that continued habilitation petition is dismissed, it means that they're no longer appropriate for institutional services.

Q Mr. Ingram, the Medicaid waiver, is there a specific dollar amount per day that they will pay or make available to you?

A Yes.

Q How much is that?

A It's capped at I believe 118 or 124. I'm not sure which one it's capped at.

Q And does that mean that's the most you can spend per day on any individual services under the Medicaid waiver?

A Unless you request it for an exception. I don't know how the process works.

Q But there is a process whereby you can request an exception and get more funding?

A Yes.

Q And that funding still comes from the same source? You still have to contact the county mental retardation services?

A Yes.

Q Is there some other source you can contact?

A I was just trying to make sure I was giving you a correct response when I said the mental retardation services office, because it's the Department of Medical Assistance where everything is eventually processed and handled.

Q Right. Who do you contact? Who does the DLC contact when they're trying --

A Its community.

Q What is the cost per day of treating a resident at the DLC?

A $283.

Q Now, when you start mental retardation services with the county involved, is contacting the county evaluation team the first step to getting them involved in a placement process?

A Restate your question again. I'm not sure.

Q When you're looking for placement for someone under DLC under a Medicaid waiver, is the first step in bringing in the county mental retardation services to contact the county evaluation team to come out and take a look at the person? What is the first step, I guess is really my question.

A The first step would be to set up your futures planning.

Q Okay. Once you've done your futures planning and think the person could conceivably have a community placement, when you contact the county mental retardation services, what's their first step in getting involved?

A Get all the paperwork completed.

process that operates here? I know there's a policy. Is that what you would refer to?

A A policy? No. I'm not sure I'm aware of a policy.

The process for discharge is a team function. It's a clinical multi-disciplinary team function.

Q Well, I understand it's a function of a team, but what is the process? What does the team do?

A Well, I don't know every aspect, every detail of what they do. But generally speaking, they access the individual's progress towards goals. And when they assess sufficient stability and achievement of goals for discharge to make them prepared to reasonably handle the discharge, then they reach that consensus agreement and make the discharge arrangements.

Q Are you aware of instances where the point in time arrives where the team feels the individual is ready for discharge, but there are no available community placements that meet the person's needs?

A I expect that has happened, Sue.

Q Would you care to estimate -- would you characterize that as a problem?

EXHIBIT 7(2P)

Q I mean for lay people, what percentage is allocated for hospitals? Or can you describe --

A I think I know what you're after. It essentially, and this is overly simplified, but the formula results in the regional boards being asked to return or give to the hospitals 90 percent of a previous fiscal year's allocation or something that's called their fair share, whichever is lower.

And that depends on a number of other things. But is that what you're trying to --

Q I think so. Thank you. That's sufficient, because I don't know that I could understand it beyond that.

A It's not easy.

Q But was the point of that to free up some percentage of the hospital's budget allocation for community services?

A The point was to effect a method for transferring -- for giving regional boards access to some portion of what were previously hospital resources, hospital dollars.

Q And do you know whether or not that actual amount has in fact been allocated to the regional boards, or is this still in the planning process?

A I don't think so. The formula hasn't been

A I'm sorry; I believe it's in the records that I've shown you, but I'm not -- I just don't remember that number. It is within -- I'm sure that there's a page that says overview, and it's on that, the limits of the waiver.

No, there's a -- I don't believe this is it. I believe that it's about this many pages, and it starts out overview.

MR. BLISS: We'll just go off the record one second while we look.

(A discussion was had off the record.)

BY MR. BLISS:

Q Go ahead, Mr. Hopkins.

A Yes, the -- this says that the total number of recipients is 2,109. The total number -- the total possible number. That's not the total that we're serving; that's the total number, the number that the federal government has authorized us to serve.

Q All right. Now, the number you're serving, do you know that number, under the Medicaid waiver?

A No, it's -- no, I don't. I don't know the exact number.

Q Who would have that number or where

EXHIBIT 8 (3p)

could we get it?

A Kathy Dowless, in the division.

Q Do you know approximately how many people are being served?

A Yes, approximately there would be 700 people served.

Q Why is the number approximately served so much less than the number that are authorized to be served?

A The waiver requires that -- the waiver is a combination of State and Federal dollars. And there must be 38.02 percent State dollars compared to 68 whatever it is on the other side.

And so the waiver is -- we have utilized the waiver fully to the match that we have. In other words, we have -- it's limited by the State dollars we have for the match.

Q All right, so you could serve more people if more State dollars were available?

A That's correct.

Q And there are Federal dollars available at the Medicaid matching rate?

A That's correct.

Q Okay. What percentage of funds are going -- if you know -- in the State of Georgia are

A The lapsed funds go back to the general State -- I'm not sure what you call that. In other words, by nature, that's what lapsed means. They have lapsed, and they have gone back.

Q So those funds, they're not available then for the agency to spend?

A They are not available.

Q They're just allocated but not spent; they go back to the State?

A That's my understanding.

Q Are there any discretionary funds that your agency has, just sort of free-floating funds that can be allocated on a discretionary basis?

A Not usually. The agency has -- this year the agency has some discretionary funds. The legislature appropriated I believe $300,000 additional match to be used for emergency kinds of placements. That is -- that's new. That's something that has not been available in the past.

Q Could those be used for community placements for mentally retarded people?

A Yes.

Q Okay, let me show you another document.

(Plaintiff's Exhibit Number 3 was

Q That the amount spent has decreased from 15 million to 12 million?

A 15 million 345 to 12 million 644.

Q Okay. Also with regard to interrogatory number 5 -- just with regard to what this document says -- the line item supportive living indicates that the total amount in fiscal year '95 was 29 million 651; is that correct?

A Compared to '92 of 17 million 560.

Q Yes, sir; but that has increased?

A Yes.

Q And then with regard to institutional care for persons with mental retardation -- that would be once again interrogatory number 6 -- the amount has increased over the years; is that correct?

A Yes.

Q And with regard to the amount spent on institutional care for persons with mental health -- that would be interrogatory number 8 -- that also indicates that the amount has increased over the years; is that correct?

A Yes.

Q I'm going to just read that for the record, and please tell me if I'm not reading it correctly. In fiscal year '92, it was 112 million

EXHIBIT 9 (4 p.)

473; and in fiscal year '95, 131 million 920; is that correct?

A Yes.

Q Okay, thank you. So at least with regard to this document which was produced in response to your interrogatories, the amount spent in Georgia on institutional care with regard to mental health services is substantially larger than the amount spent on community services; is that correct?

A The dollars indicate that.

Q Now, do you know -- based on any information that's been produced to you -- Commissioner, whether or not there are individuals in Georgia in mental health institutions that need to be moved into the community?

A No.

Q You have no knowledge of that?

A No.

Q How about with regard to the HB 100 and the funding for that Bill; is there -- is that not related to an effort to move people from institutions into the community?

A Yes.

Q So is that -- is it true then that there are some people in these institutions that need

under the terms of House Bill 100.

Q Okay. So you're concerned less -- correct me if I'm wrong -- that the hospitals might not be maintained adequately to protect people who need to be there? Do you have a concern about that?

A I have a concern for the protection of all mental patients in Georgia in or out of hospitals.

Q Well, I know, Commissioner. But I'm asking you because it's an important issue for me and for the individual who is involved in this case. What is your impression now, your concern, as it relates to institutions and their role; that they be protected and maintained; that they be -- that the appropriations for the institutions be reduced; that they be increased? I mean do you have any opinion at all?

A My concern as the Commissioner is that they operate and fulfill their mission as efficiently as possible, serving -- giving the necessary service to the appropriate patients.

Q Could I interpret that to mean that perhaps they could be reduced in size and then still fulfill that mission?

A Yes, they could be.

Q Or are you saying it's not correct?

A I'm saying I have no personal knowledge. I would assume that Mental Health would be accurate in what they wrote.

Q Okay. Would you assume they're accurate then when they also say that 99 percent of their employees work in State hospitals?

A I would -- I would assume they were able to get that somewhere.

Q All right.

MS. JAMIESON: I would like to have this marked as an exhibit, please.

BY MS. JAMIESON:

Q Would you kindly identify the document for the record?

A It's Division of Mental Health, Mental Retardation and Substance Abuse at a Glance; published September 1994.

(Plaintiff's Exhibit 5 was marked for identification.)

BY MS. JAMIESON:

Q Commissioner, I'm looking at another document which we don't need to identify. I just want you to tell me if you agree with this statement that the role of the Department of Human Resources --

care homes; is that correct?

A Yes.

Q But Mr. Parrish, did she need more structure than a personal care home, in your opinion?

A Yes.

Q But it wasn't available; is that correct?

A Correct.

Q So you were left with personal care homes as the only option for her?

A Yes.

Q Did you ever think about mental retardation services for her during that period?

A No.

Q You never considered it?

A If I did, I can't recall it.

Q That's fine. I'm just wondering whether -- well, let me just ask you. And if you can't recall, just repeat that, whether you felt that there would be no hope, whether mental retardation service -- well, let me ask you this. Is it difficult to place people in mental retardation community placements, in your experience?

A Yes.

Q In your experience, how has that been difficult?

(Plaintiff's No. 1 was marked for identification.)

BY MS. JAMIESON:

Q Would you just look at that briefly and see if that reflects your earlier testimony about what your job responsibilities are, if there's anything else there that triggers your memory about other responsibilities you may have.

Mr. Parrish let me clarify my question. I don't mean to suggest that you've skipped something important. But I would like you to check that and make sure. My area of interest is the discharge planning function, and you've testified that that's one of your functions.

A Yes, that is one of my functions.

Q There's nothing else in that particular area that you want to add, is there? I think it's covered.

Okay. Thank you. All right. Let me show you another exhibit. This is to clarify to some degree and help you remember your work with E.W.

A Uh-huh. Here's one.

MS. DOWNING: Thank you.

BY MS. JAMIESON:

Q Would you identify that document. You can

just read the title at the top for identification purposes.

A Okay.

Q Would you read it, Mr. Parrish?

A Discharge summary.

Q And the dates, please?

A 11-19-94, 12-2-94.

Q Okay. Now, just glancing at this document, can you recall -- this is apparently a document reflecting on E.W.'s admission from an address on Lakewood Avenue.

A Uh-huh.

Q Do you know where she was living? Was that a personal care home?

A Yes.

Q Do you recall the name of that personal care home on Lakewood Avenue, or did it have a name?

A I can't recall whether it had a name or not.

Q If you just look at the very bottom of that paragraph entitled psychiatric history where it says this is her 31st hospitalization here, is that your memory, that she'd been hospitalized approximately that many times?

A Roughly, yes.

Q Well, let's just say is this the kind of discharge summary that is typically prepared when a client is released from the hospital?

A No.

Q No?

A From me?

Q No, not by you. I'm just saying each time a client is discharged, is a discharge summary prepared and placed in the record like this?

A By the physician.

Q By the physician?

A Uh-huh.

Q But not by the social worker?

A No.

Q This is a physician document; right?

A Yes.

Q So just for clarification, this document indicates that she was discharged on December 2nd, 1994; is that correct?

A Uh-huh. Yes.

Q And does it indicate that she had been admitted from a personal care home on Lakewood Avenue? Is that what this would indicate?

A Repeat the question. I'm not following you.

Q Does this document indicate that E.W. was discharged on December 2nd from Georgia Regional?

A Uh-huh.

Q And does it indicate that she was admitted from a personal care home on Lakewood Avenue?

Well, you can't figure it out?

A I can't, no.

Q Does it indicate that she was living at 1579 Lakewood Avenue as her address?

A Yes.

Q I think you testified that that was a personal care home. Are you sure that it is?

A I'm sure that it's a personal care home.

Q Thank you. That's all. You didn't prepare this document; right?

A No.

Q All right. I'd like to show you this document. Maybe you could look at your lawyer's copy.

Have you seen this? Would you identify this document, Mr. Parrish. Just read the title at the top, please.

A Client information and census, Atlanta Regional, chart number, search screen.

Q Have you ever seen a document like this

before?

A Yes.

Q What is it, please?

A This come out of the computer, had all the patients' admissions and discharge.

Q And is this the computer list of admissions and discharge for E.W.?

A It seems to be, yes.

Q We won't take the time now, but if we were to count these and it came to about 30 or 31, is it correct that that reflects the number of admissions to this hospital over the years? Is that what this document reflects?

A Yes.

Q I'd like you to look at the top, Mr. Parrish. Do you see on the second line down, discharge date, December 2nd, '94?

A Yes.

Q Okay. And then above that, the top line, it says -- actually it says date enrolled, which I assume means admission, 12-20-94; is that correct?

A Yes.

Q All right. So just to get us into a context, according to this document, anyway, that would have been her last admission, is that right,

was this an appropriate place for E.W. at that point in time, December 29?

MS. DOWNING: I object, because he's already stated he had a yes and a no. And he gave part of the yes. I don't think he's given the no part.

BY MS. JAMIESON:

Q Please give the no part.

A The no part is I wouldn't have chose Ponce Manor.

Q Why not, please?

A Because it doesn't provide a whole lot of structure. Some, but not a lot.

Q What would you have chosen?

A Probably at that time I would have chosen a personal care home which had less people.

Q Can you explain just briefly why for E.W. a personal care home with less people would have been in your opinion better.

A Because E.W., in my opinion, needs a lot of attention, where a place like Ponce Manor doesn't provide a lot of attention.

Q Does E.W -- in your opinion is it also a problem with regard to adequate supervision?

A In terms of placement?

Q Yes.

A Ask the question again, if you would.

Q Does Ponce Manor in your opinion have enough supervision?

A In my opinion, no.

Q Isn't it true that in fact she walked or threatened to walk in front of a car that very day she was there?

A According to the admissions assessment disposition, yes.

Q So are you able to conclude anything about whether there is sufficient supervision there for E.W. from that fact?

A Yes.

Q What would your conclusion be?

A That she wasn't well supervised.

Q All right. Moving on to Exhibit 8, would you take just a minute to look at the documents.

Mr. Parrish regarding Exhibit 8, would you identify the document on the top of the list of the pile of documents.

A Discharge and after-care form.

Q And did you prepare this form?

A Yes, I did.

Q Does this indicate that she was discharged

A Yes.

Q Can you just tell us what you remember.

A That -- and I really need to refer back to my progress note at the time, but that she attacked the home provider, did something to the home provider.

I really can't remember what she had done to the home provider. And the end results were that she was restrained by the home provider, and the home provider tried to pray the demons out of her or something to that effect. I can't be accurate on that.

Q But do you have an opinion or can you recall whether you felt that was inappropriate on the part of the personal care home provider to pray the demons out of her, to restrain her and pray the demons out her?

A In my opinion, yes, I felt that was inappropriate.

Q And if you'd refer to the last page there, Mr. Parrish, what is that document, please? It has prn on it for clarification, but what is that document?

A This is the MAR sheet.

Q And MAR means?

Q Does it indicate that E.W. was discharged again on February 7th, 1995, from Georgia Regional?

A She was then placed on a trial visit, yes.

Q A trial visit?

A Yes.

Q Okay. And to a placement at 169 Moreland Avenue?

A Yes.

Q Do you recall if that's a personal care home?

A Yes, it is.

Q Do you know which one that is?

A That's Graves personal care home.

Q All right. Have not identified any specific date for her readmission after the discharge on January 26th. But she was obviously re-admitted, is that correct, because she's now being discharged again.

MS. DOWNING: Just for clarity, let me point out that there's a trial visit date on the form and the discharge date. And although you've use term discharge, I think both you and Mr. Parrish have -- we're actually talking about trial visit dates.

BY MS. JAMIESON:

that placement?

A No, I didn't.

Q Who did?

A Janet Stewart, her Fulton County case manager.

Q But you know Graves. You testified you've been there and you're familiar with it.

A Yes.

Q Was that an appropriate placement for E.W., in your opinion?

A It was a good placement for E.W.

Q Why do you use the word good instead of appropriate?

A Because at this point, I don't know what is appropriate for E.W.

Q Well, I'm going to ask you to look on the document in front of you, social history, which you have; is that correct?

A Uh-huh.

Q All right. And it is I believe a document you prepared; is that correct?

A Yes.

Q I'd like you to look on the back where it says social worker's assessment.

A Uh-huh.

Q And would you read that section in the record, please, beginning with "I feel."

A "I feel that this patient have poor interpersonal skills relating to her MR. Patient have some control of her acting-out behavior but haven't been in any program to focus directly on teaching patient interpersonal skills. Patient ability to learn is limited. Therefore, without one-to-one focusing on teaching patient to get her needs met without making suicidal threats, verbal abuse to others or destroying property will continue the cycle for patient returning to the hospital."

Q Does that indicate that she can't get that sort of teaching in a personal care home? Is that what you were saying here? You say hasn't been in any program. What did you mean by that?

A Hasn't been in any program to focus directly on teaching her interpersonal skills, to my knowledge, that she hadn't been in any programs to teach her interpersonal skills.

Q And that that's why she's in and out of the hospital cycle? Is that your opinion here?

A Yes.

Q Well, then I have to ask you why would you keep placing her in personal care homes if this was

your opinion?

A Well, at the time, there were no other places, to my knowledge, that she hasn't already been in that would take her back that could provide her the skills that she needed.

Q Okay. But now here you're expressing your opinion that the problem is related to her mental retardation; is that correct?

A Yes. I said her interpersonal skills relates to her MR.

Q Did you consider at that point whether or not a mental retardation program might be appropriate for her?

A No, I did not.

Q Why not?

A Mainly due to her personality disorder. And that's what the team was basically focusing on.

Q At least at this point, Mr. Parrish, were you disagreeing with the team? You seem to be focusing here on the mental retardation issue.

A I was not so much -- I was not disagreeing with the team. Besides her personality disorder, looking at her records, her secondary diagnosis was a mild MR.

Q But you're saying here that she's just

Q What else do they do?

A In terms of her needs, well, taking care of her daily living skills, that's one of the main things. But the day treatment thing, the program is one of the things that I felt and the treatment team felt that E.W. needed, day treatment, some kind of day treatment.

Q Didn't it appear by now that she needed some behavioral management in her placements since she was returning after a day, not even a day?

A Yes. I would agree.

Q And Graves doesn't provide that, does it?

A Within the personal care home?

Q Yeah, within the personal care home.

A I couldn't say.

Q You didn't know whether or not Graves would provide behavioral management programs?

A I can't say that they do or they don't in terms of behavior management program. I couldn't say.

Q Do you know of any personal care home that provides a behavioral management program to its residents?

A I don't know.

Q Have you ever had a client that -- well,

you've just said you think E.W. needed that; right?

A Yes.

Q Well, wouldn't you have to find out, then, if the personal care home provided what she needs?

A Well, I would put it like this. Some personal care homes provide more structure than others.

Q But I'm talking about a behavioral management program of some sort, as you pointed out, to help her learn, to teach her how to deal with her behavior problems.

A No. I don't know of any personal care home that provides that.

Q Do you know of any community programs that provide that?

A Not behavioral, no.

Q But do you agree that's what E.W. needs?

A Yes, some, yes. Yes.

Q Do you have any memory, Mr. Parrish, about whether or not when she returned from Graves that same day, February 7th, do you recall whether she was put on any more trial visits while you were her social worker?

A No, she wasn't.

Q Okay. I just wanted to clarify for my own

A March 27th, 1995.

Q Okay. You've already testified that you have some recollection of that being a complaint about her discharge to a shelter.

A Yes.

Q And does that document -- I don't know if you've ever -- did you ever see that document, which is a letter?

A I believe so, yes.

Q Okay. When you say I believe so, you're referring to the March 20th letter to Dr. Fields or the March 27th letter to me from Mr. Watson?

A The March 20th letter.

Q Okay. You've seen that before?

A Yes.

Q And how about the March 27th letter? That's the one on top. I notice many copies were sent, but I'm not sure you ever saw it.

A I don't think I have.

Q Well, were you aware of that letter or of some communication from Mr. Watson which resulted in a decision not in fact to discharge E.W. to a shelter?

A Some, yes.

Q So that decision to release E.W. to a

shelter in March was reversed; is that correct?

A Yes.

Q And it was reversed because this complaint was filed; is that correct?

A Well, I can't say. I really can't say if that's why.

Q Well, you were planning -- I assume it was a team decision, is that correct, but you were planning to discharge E.W. to a shelter?

A E.W. was told that she would be discharged to a shelter.

Q Did you not contact the Homeless Task Force see if there was a location for her?

A No, I did not.

Q If that's in the progress notes, could it be you don't recall doing that?

A If it's in the progress notes -- well, I don't recall. I don't recall.

Q All right. So is your testimony that you told her that but you didn't proceed to actually discharge her to a shelter?

A No, I didn't. I did not proceed to discharge her to a shelter.

Q But did the team decide that that was what would happen to E.W.?

A The team did say to tell E.W., yes.

Q My question was, Mr. Parrish, did the team decide that this is what would happen to E.W., that she'd be discharged to a shelter?

[Attorney confers with witness]

BY MS. JAMIESON:

Q What was your answer?

A Okay. Ask the question again.

Q Okay. Did the team decide to discharge E.W. to a shelter?

A Because she refuses, after refusing treatment or other placement, yes.

Q And that was in March of '95?

A I would assume. I can't recall the exact date.

Q Okay. And did the team change their mind and decide not to discharge her to a shelter after all?

A No.

Q Can you explain what you mean by that?

A As you just said to me, that the complaint is what reversed the actions. I really don't know.

Q You're saying she was not in fact discharged to a shelter; is that correct?

A Right.

doctor never entered the discharge order?

A I can't say he did or he didn't. But if he never wrote the order, then I never would have acted on it anyway.

Q Do you have an opinion now, today, Mr. Parrish, whether that team decision to discharge her to a shelter was an appropriate decision or not?

A Well, as I just stated, it was E.W. refusing treatment and refusing other housing. And I think that's where the decision stems from.

Q You think that was an appropriate decision based on the circumstances at the time to discharge her to a shelter? Is that what you're saying?

A No, I'm not.

Q Then was it an inappropriate decision?

A If we acted on it, I would say yes, it was an inappropriate decision. But we never acted on it, so I can't say it was so inappropriate, because we never made the discharge to the shelter.

Q I'm just asking you whether the decision was appropriate or inappropriate. I understand she was never actually discharge to the shelter. But you did testify that your team made a decision to discharge her to a shelter.

A Uh-huh.

Q Speaking today, in your opinion, was that an inappropriate decision?

A Yes.

Q Is the major behavior problem, Mr. Parrish, in your opinion -- well, let me just ask you. What are E.W.'s behavior problems if you could list them, please?

A Let me think back.

Q Do you have to think? Oh, that's right, because it's been since the fall of '95.

A Yeah. E.W. can be verbally abusive, threatening at times, can be combative, refuses to follow structure a lot of times.

That's all I can think of right now.

Q And are these behaviors that could be addressed in a behavior plan?

A Read back. What did I say?

Q Verbal abuse, threatening, combative and difficulty with following structure.

MS. DOWNING: I think he said refused to follow structure.

BY MS. JAMIESON:

Q Refusing to follow structure.

A And can they be used in what, now?

Q Could those behaviors be addressed in a

team?

A Sometimes, through the social worker.

Q Okay. After this event where E.W. was going to be discharged to the shelter and then was not in fact discharged, and this staffing in April that we referred to, okay, this is the period time we're talking about, from that point until you were no longer her social worker, which would have been -- I think it's actually September of '95. But you remember it being in the fall; is that correct?

A Yeah.

Q During that period of time, what placement efforts did you make on E.W.'s behalf?

A None.

Q Why is that?

A During that period of time, E.W. was, if I recall correctly, and I would have to look back in the records, E.W. was having a urinary problem. We also were trying to get her linked up with a vocational rehabilitation program here.

We also were trying to do some educational testing to see where she was, what was her base line in her education. And we were working and we were trying to get E.W. to be more consistent in terms of going in groups. So we was trying to get an accurate

assessment of E.W. and her ability to do things while she was here.

Q If there were a program in the community that could deal with this urinary medical condition, do you know of any reason why that couldn't be dealt with outside of the hospital? And I'm just talking about the medical problem.

A If there was --

MS. DOWNING: Wait, wait, wait. Are you asking him about the medical problem?

MS. JAMIESON: Are you going to say only a doctor could answer that?

MS. DOWNING: The way it's phrased, I would think so.

MS. JAMIESON: I think that's probably correct, so I won't ask that.

Q You said that during that period you were linking her up with vocational rehab services; is that correct?

A Yes.

Q Are there, to your knowledge, vocational rehab services in the community away from Georgia Regional?

A Yes.

Q Did you consider linking her up with the

off-campus vocational rehab programs?

A Providing she had got -- our rehabilitation program, vocational program here links up and takes out people to the programs out in the community on a daily basis. And that would be what would happen if we could have got her linked up here.

Q Did you not get her linked up here?

A During the time when I was her case manager, we linked her, but she refused to go.

Q Did you try linking her to a community program, or you're saying it never got to that point?

A It never got to that point.

Q So if a person refuses go to the on-campus program, they don't have the option to go to the off-campus program; is that correct?

A Yes, you do have the option.

Q But you didn't feel -- let me understand.

A Because our vocational rehabilitation program here would have taken her on a daily basis to the vocational rehabilitation program off campus every day.

Q But they don't get to do that right away, do they? Don't they have to kind of make it through the on-campus program first before they're taken off campus? Is that correct?

A That's pretty much correct.

Q So if she refuses to even go to the on-campus program, she's never going to make it to the off-campus program; is that correct?

A That's pretty much correct.

Q Okay. The educational testing and other thing that was going on, can that be done off the hospital grounds. What kind of testing is that?

A To see her base lines in terms of her reading, her writing, and some other things that I'm not aware of in that field. We just wanted to get just a feel on where she was in terms of her education.

Q And then the fourth thing you mentioned is having her go consistently to in-patient groups; is that right?

A Yes.

Q So for those reasons, you did not look for placements for E.W. off campus?

A Uh-huh. Correct.

Q Oh, I wanted to show you one thing in the progress notes just so that on the records it's clear.

A Okay.

Q What I would like to show you is just a

CS-003
04/17/95 10:31 AM

CLIENT INFORMATION AND CENSUS
ATLANTA REGIONAL
CHART NUMBER SEARCH SCREEN

3

CHART NUMBER : 000013443 SSN: 260783201
CLIENT NAME : WILSON , ELAINE B
DATE OF BIRTH: 09/13/1951 SEX: F RACE: WH

TAG	DATE ENROLLED	ADMISSION TIME		DISCHARGE DATE	CLIENT LOCATION
	12/20/94	1015	PM	00/00/00	999100060060
	11/19/94	0828	PM	12/02/94	999100060060
	10/08/94	0130	AM	11/09/94	999100060060
	09/12/94	0955	PM	09/26/94	999100025025
	05/19/94	0110	AM	06/01/94	999100025025
	05/04/94	0342	PM	05/06/94	999100025025
	04/20/94	0320	AM	04/28/94	999100025025
	01/25/93	0900	AM	02/12/93	999100070070
	09/17/92	1125	PM	10/07/92	999100025025
	09/17/91	1135	PM	10/15/91	999100025025

MESSAGE:
4B O-001

CS-003
04/17/95 10:32 AM

CLIENT INFORMATION AND CENSUS
ATLANTA REGIONAL
CHART NUMBER SEARCH SCREEN

CHART NUMBER : 000013443 SSN: 260783201
CLIENT NAME : WILSON , ELAINE B
DATE OF BIRTH: 09/13/1951 SEX: F RACE: WH

TAG	DATE ENROLLED	ADMISSION TIME		DISCHARGE DATE	CLIENT LOCATION
	08/17/91	0928	AM	08/27/91	999100025025
	08/29/88	0430	PM	10/03/88	999100060060
	05/27/88	1130	AM	06/13/88	999100025025
	07/16/87	0131	PM	09/29/87	999100035035
	02/24/87	0245	PM	02/27/87	999100025025
	12/13/84	1201	AM	02/05/85	999100004004
	09/04/84	1201	AM	10/03/84	999100004004
	08/24/83	1201	AM	10/14/83	999100004004
	03/25/82	1201	AM	04/12/82	999100002002
	10/21/81	1201	AM	12/17/81	999100004004

MESSAGE:
4B O-001

PLAINTIFF'S EXHIBIT
3
3-11-96 MG
PENGAD-Bayonne, N.J.

CS-003 CLIENT INFORMATION AND CENSUS
04/17/95 10:32 AM ATLANTA REGIONAL
CHART NUMBER SEARCH SCREEN

CHART NUMBER : 000013443 SSN: 260783201
CLIENT NAME : WILSON , ELAINE B
DATE OF BIRTH: 09/13/1951 SEX: F RACE: WH

TAG	DATE ENROLLED	ADMISSION TIME		DISCHARGE DATE	CLIENT LOCATION
	08/07/81	1201	AM	09/02/81	999100002002
	07/17/81	1201	AM	08/05/81	999100002002
	06/29/81	1201	AM	07/10/81	999100002002
	06/10/81	1201	AM	06/16/81	999100004004
	05/01/81	1201	AM	06/02/81	999100004004
	03/28/81	1201	AM	04/14/81	999100002002
	08/27/79	1201	AM	09/06/79	999100004004
	07/23/79	1201	AM	07/26/79	999100004004
	08/07/78	1201	AM	08/16/78	999100004004
	06/14/76	1201	AM	08/20/76	999100001001

MESSAGE:
4B O-001

CS-003 CLIENT INFORMATION AND CENSUS
04/17/95 10:33 AM ATLANTA REGIONAL
CHART NUMBER SEARCH SCREEN

CHART NUMBER : 000013443 SSN: 260783201
CLIENT NAME : WILSON , ELAINE B
DATE OF BIRTH: 09/13/1951 SEX: F RACE: WH

TAG	DATE ENROLLED	ADMISSION TIME		DISCHARGE DATE	CLIENT LOCATION
	05/13/75	1201	AM	09/25/75	999100002002
	03/07/75	1201	AM	04/28/75	999100002002

5
5 Wnd 2

MESSAGE:
4B O-001

[redacted]

107

History: 1 Problem Focused; 2 Expanded; 3 Detailed; 4 Comprehensive Exam: 5 Problem Focused; 6 Expanded; 7 Detailed; 8 Comprehensive
Decision: 9 Straightforward; 10 Low; 11 Moderate; 12 High Other: 13 Record Review (countersign) 14 Family Consultation (note time)

Date	Time	Disc.	S/S#	Notes / Signature
3/20/96	10 P.M.	NSg	A	A-patient requested to write in her chart that she wants to be discharged tomorrow, A-A memo will be left under Dr. Patel door Re: pt's request. P-will follow-up upon request. — M. S. Mewy RN
3/21/96	5:00 AM	NSg	—	(Nursing Entry) Weekly charting 11P–7A Ms Wilson in bed sleeping when Rm Ck's was made, Ms Wilson was sitting up in day area on Beginning of this shift and went to be shortly after, Voice no C/o at this time, Cont to obs closely — [illegible] RN entry —
3/21/96	8:30 pm	NSg	A	A-patient has been calm + cooperative this p.m., sitting down on unit talking to other peers) A- No delusional ideation voiced, cooperated c̄ Tx plan → 300cc clear yellow urine obtained P- will continue to encourage cooperation with Tx plan + good behavior — M. S. Mewy RN
3/22/96	10:15 AM	NSg		Pt. refused to go to med clinic for her physical. She got her coat and started out then said I don't want to go. She turned back & returned to her rm. and could not be persuaded to go. Pt. refused catheterization saying I don't want to do it. [illegible]

EXHIBIT 11
(50)

History: 1 Problem Focused; 2 Expanded; 3 Detailed; 4 Comprehensive Exam: 5 Problem Focused; 6 Expanded; 7 Detailed; 8 Comprehensive
Decision: 9 Straightforward; 10 Low; 11 Moderate; 12 High Other: 13 Record Review (countersign) 14 Family Consultation (note time)

Date	Time	Disc.	S/S#	Notes	Signature
4/23/96	11:15 pm	NSC		Late Entry Note: Client was taken to Grady Hospital on 4-22-96 upon arrival walked away from staff. Notified the Orange nurse and Grady security police. Client later found and brought back to staff at the Gyn Clinic. Client cursed staff out and missed appointment at the Gyn Clinic. Client's behavior will be monitored & observed on team	S. [illegible] H5182
				DATE 4-24-96 TIME 1:50 A 24 HR MEDICATION CHART CHECK COMPLETED SIGNATURE Clovis D. Clark LNSC	
4/24/96	1:15 A	NSO		PRN Follow Up: Approached this writer requesting "sleep medication". Medicated @ this time c Ativan 2mg po x1.	E Blount [illegible]
4/24/96	2:15 A	NSO		PRN Follow Up: Resting quietly c eyes closed. No further complaints voiced.	Blount [illegible]
4/24/96	2P	SW	3	Social Service D-Completed family session c pt & mother. We reviewed Elaine's performance last wk c behavior plan, noting an increase in her making delusional statements. Elaine shared her belief that she has a daughter. Mother assured her she had no children and mother told pt that making these false statements	

Progress Note

History: 1 Problem Focused; 2 Expanded; 3 Detailed; 4 Comprehensive
Exam: 5 Problem Focused; 6 Expanded; 7 Detailed; 8 Comprehensive
Decision: 9 Straightforward; 10 Low; 11 Moderate; 12 High
Other: 13 Record Review (countersign) 14 Family Consultation (note time)

* Time: List time in minutes only if counseling was the major component of the provider/patient encounter.

Patient Identification

WILS[illegible] ELAINE B.
1-44-[illegible] IXU
WF 09/13/51 FSC
GRH/ATLANTA

Date	Time	Disc.	S/S#	Notes Level drop Charting Signature
4/27/96	4Pm	NSg		S- Facility police brought patient back on the unit - Caught at the gates and patient attempted to go AWOL. When the facility police asked pt where she was going, she said "I am a level 4, but I am going to use it to go AWOL. When pt arrived on unit, pt was told by this writer that her level will be dropped, she said "I don't care, I was going to leave this place". O- pt is hostile + agitated, and AWOL risk, therefore her level is 1 to 2 R until evaluate by Dr. Patel. P- will continue to monitor behavior + AWOL Risk — M. Spleen, RN
				— R.N entry —
4/27/96	9Pm	NSg		pt has been Calm + cooperative since returning on unit; patient cooperative & cath procedure, 300cc clear yellow urine obtained, will continue to monitor — M. Spleen, RN
4/28/96	12Am	Nsg	—	24° medication order ✓ Completed — M. Spleen, RN
4/28/96	7:50 AM	NSG		Late Entry for 4/27/96 7:00 pm.
				Release Note
				D: Client released from seclusion

Progress Note

History: 1 Problem Focused; 2 Expanded; 3 D...ed; 4 Comprehensive
Exam: 5 Problem Focused; 6 Expanded; 7 Detailed; 8 Comprehensive
Decision: 9 Straightforward; 10 Low; 11 Moderate; 12 High
Other: 13 Record Review (countersign) 14 Family Consultation (note time)

* Time: List time in minutes only if counseling was the major component of the provider/patient encounter.

Patient Identification

...NE B.
...ATLANTA ...SC

Date	Time	Disc.	S/S #	Notes R N charting	Signature
5/7/96	6 45 pm	NSg		S- patient brought back on the unit by facility police - stated that patient was on her way to be off campus upon arrival on unit, patient was loud, hyperverbal, calling names to staff members using racial slurred when asked why did she try to go off campus? she said "I was going to walk in front of a marta bus and kill myself." pt was asked is there any reason why she wanted to do that, she said, "I don't want to talk about it." pt was informed that her level was going to be dropped, she said "I don't care." A- pt is at risk to (as) leave facility ≅ permission and has the intention to hurt herself through passing vehicle, therefore her level is dropped to level I at this time P- will keep level I monitoring until Dr. Patel notifies and will encourage pt to ventilate angry feelings in calm + appropriate manner	Marie Sklen, RN

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History: 1 Problem Focused; 2 Expanded; 3 Detailed; 4 Comprehensive Exam: 5 Problem Focused; 6 Expanded; 7 Detailed; 8 Comprehensive
Decision: 9 Straightforward; 10 Low; 11 Moderate; 12 High Other: 13 Record Review (countersign) 14 Family Consultation (note time)

Date	Time	Disc.	S/S#	Notes 297	Signature
6/20/96	10:15 Am	NSG		PN entry —	
				Pt. cooperated c catheter procedure after missing 6am scheduled time - we obtained 300 cc light amber urine and pt. reported no discomfort during procedure.	
					Reeya Cabrera
				Treatment Note	
6/20/96	7pm	NSG		patient straight cath, 300 cc clear yellow urine obtained, pt calm + cooperative, no verbal abusive behavior noted — MS Hx using racial slurs this pm. Refused 9pm medication this pm. — Edlenet	
6/21/96	9pm	NSG			
6/21/96	11:30p	Nsg.		Pt. was seen walking off the GRHA grounds by facility police. She told them she was going to walk in front of a car to kill herself. She was brought back to the unit & restricted to the unit until further evaluation of level per MD. Pt. later explained she was humiliated publically by (KA) a female pt who announced in front of a group of people @ the dining room that pt had claimed to have gone to bed c EC (staff). Pt stated E.C. laughed in response to this & this humiliated her. Pt. reported cath & claims continued St. Vidal	

GEORGIA REGIONAL HOSPITAL AT ATLANTA PSYCHOLOGICAL EVALUATION CONSULTATION	Do Not write-- Identification Stamp Only

REFERRAL INFORMATION: Chart Number: 13443 (Omit if stamped above)

Name: Elaine Wilson — Number of Hospitalizations:

Age: 43 Birth Date: 9-13-51 — Current Meds:

Education: Special Ed. Reads and writes — Current Dx: Not resolved

Marital Status: S or D — Occupation: Brief, low-level, infrequent

Referring Physician: Dr. Patel — Referral Date:

Reason for Referral: There were both diagnostic and management issues. Are the patient's symptoms and behaviors the result of an Axis II personality disorder, and therefore less amenable to drug therapy and somewhat under her voluntary control? And what can be done to change the behaviors, which have repeatedly resulted in failed placements, and which make life here on the Treatment Unit difficult for her and for patients and staff in contact with her? A number of additional issues were raised in internal peer reviews.

Methods of Evaluation: All GRHA charts were reviewed. These included a 1987 psychological evaluation by Dr. Lynn Cooper, supervised by Dr. Stephen Ziegler. Elaine's mother provided copies of psychological and related evaluations done at Gracewood when Elaine was placed there as a teenager ;and of a current evaluation by Dr. June Kaufman, a psychologist in private practice who has extensive experience with mental retardation. Here at GRHA, I administered the Stanford-Binet Intelligence Scale, 4th Edition (1986), as well as portions of the WAIS-R. Elaine was observed on the unit, interviewed and counseled on a number of occasions by this writer and by Ms. Gerda Abbey, a psychology intern.

Background History: Elaine is said to have had a normal birth and normal development until around age one, when she was hospitalized with a fever and symptoms suggesting a meningitis or encephalitis. Elaine's biological father is said to have been an abusive alcoholic who divorced and left the family when Elaine was two. She has not seen him since. Elaine's mother reports that there were increasing and prominent behavior problems subsequent to these events (in contrast to the behavior of the older sister). On reaching school age, Elaine did poorly in public school and later had to be placed in private school for special education, where she still did not do very well.

During puberty, increased behavior problems including belligerence, tantrums, and sexual misbehavior led to Elaines's admission to Gracewood State Hospital at age 14, where staff clearly regarded her developmental and behavioral problems as "organic" in origin. There are reports in the old charts that Elaine said she was sexually abused at about age 12 by her stepfather, and she still makes this claim if asked about it. I did not find any indication that this abuse was ever corroborated by Elaine's mother or by any other source. Because Elaine has frequently been delusional about her sexual and social experience, I cannot form an opinion as to whether she was actually sexually abused, but her belief may have the force of reality.

School problems notwithstanding, Elaine did develop some ability to read and write, and verbal expression and comprehension were relative strengths for her. In 1966, at age 14-5, she was given the WISC (apparently by a private examiner) and the scores were Full Scale IQ 60, Performance IQ 51, and Verbal IQ 75. A Peabody Picture Vocabulary Test given in 1968 did not suggest as high a level of verbal functioning: the Peabody "IQ" was only 54 with a mental age of about 6 years. In 1969 the Peabody was repeated, with an "IQ" of 57; and on the Slosson Intelligence Test she had an IQ score of 48 with a mental age estimate of 7 years 8 months. The Gracewood evaluators saw her as high in the moderate range of mental retardation, or perhaps mildly to moderately retarded.

She was at Gracewood for 3 or 4 years, making little progress and being unable to hold job assignments for long because

EXHIBIT 19 (3 p.)

of a "belligerent, sassy attitude toward her supervisors." After discharge, she was unable to live either with or apart from her mother. She spent considerable time at Central State Hospital, where a (questionable) diagnosis of schizophrenia indicates that Elaine may have been showing delusional and hallucinatory behavior similar to that seen today.

Her first admission at GRHA was in about 1975, when she was described as having an IQ too high for MR programs. (No test result is cited.) She was frequently readmitted through the early '80s, when most attending physicians regarded her as mentally retarded with behavior problems, but they said she did not have thought disorder or psychosis. She was often discharged with no medications, and with little behavioral improvement, as far as can be judged from progress notes. When neuroleptics were used, it is not clear that they had any effect other than general tranquilization.

Elaine reported being married for about 3 years in the early 80s, but said that she was beaten by her husband, causing a miscarriage. There is another report that the mother had the marriage annulled after a much shorter period. Elaine also held a couple of menial jobs for brief times through this period.

Elaine's pattern of typical problems continued until 1987, when she was admitted for attacking a home provider and the provider's grandchild with a knife. A psychological evaluation was requested to confirm or rule out a diagnosis of personality disorder. A WAIS-R was administered, along with a Bender Gestalt and the House-Tree-Person drawings. The results for the WAIS-R were Verbal IQ 69, Performance IQ 66, and Full Scale IQ 66. [Note that the Verbal and Full Scale IQs are each a point lower than originally reported because of correction of a scoring error on the Comprehension subtest.] The examiner noted that Elaine had relative strength in a good attention span and fairly good expressive verbal skills, but that she was "particularly weak in social comprehension, has a very low fund of general knowledge, and shows some evidence of organic impairment." The Bender drawings also were viewed as indicating organicity, although they could also be viewed as developmentally immature. The H-T-P drawings suggest arrested personality development, especially the human figure drawing. Dr. Cooper and Dr. Ziegler diagnosed Organic Personality Syndrome, an Axis I DSM-III-R diagnosis. The attending physician evidently did not concur; Elaine was discharged with a diagnosis of Adjustment Reaction.

On the next admission, in May/June of 1988, Dr. Thaliath tried Elaine on Trilafon and Tegretol and reported a remarkable response. On the subsequent admission, Dr. Amin tried Trilafon and Tegretol again. He was unsure of the results, but progress notes show at least that the patient did improve. She was diagnosed as schizoaffective. Over the next few admissions there appeared to be an increase in low grade delusional beliefs, as in her stating that people were putting things in her food. Dr. Thaliath tried Tegretol on two different admissions with less success than previously. On one admission she improved, but then soured as discharge approached. Drs. Patel and Hopkins used a diagnosis of psychotic disorder NOS for the next three admissions; both also noted borderline personality characteristics. For admissions in 1994 and 95, Dr. Patel diagnosed only borderline personality disorder and mild mental retardation. He did not see evidence of psychotic symptoms, saying that her delusional statements and reports of hallucinations were either manipulative behavior or the result of weak ego boundaries in a retarded individual. He continued to use neuroleptics at most times because of Elaines's agitation and verbal aggression, which were a problem on the unit.

Elaine repeatedly refused or "blew" placements and refused to cooperate with the treatment team on placement issues, so at one point the possibility of discharging her to a shelter brought intervention by her mother and by Protection and Advocacy. As a result, she was referred to Dr. June Kaufman for psychological evaluation. Dr. Kaufman has considerable experience in evaluating developmental disabilities. Dr. Kaufman apparently obtained adequate cooperation and effort from Elaine, some anxiety and delusional behavior notwithstanding. She obtained WAIS-R scores of Verbal IQ 66, Performance IQ 56, and Full Scale IQ 58. However, Dr. Kaufman noted that the Performance IQ was almost certainly an overestimate, because of Elaine's failure to perform three subtests on the Performance Scale. The WAIS-R gives a scaled score of 1 even when the raw score is zero, as on these subtests. This placed both the Performance IQ score and the Full Scale score in question.

In addition, Dr. Kaufman obtained a PPVT-R (Peabody Picture Vocabulary Test-Revised) standard age score of only 44, with an age score of only 4-10, which raised some doubts about the WAIS-R Verbal IQ. An age score for a human figure drawing was only 4 1/2 to 5 years. Finally, Elaine's adaptive behavior composite standard score on the Vineland was only 31, very low for someone with a history of Wechsler IQs in the 60s. While Dr. Kaufman also reported a TONI-2 (Test of Nonverbal Intelligence-2) score of 63, she concluded that in general, Elaine was functioning in the upper portion of the moderate range of intellectual functioning. Dr. Kaufman recommended placement in a highly structured residential home appropriate for an individual with mental retardation and behavioral/emotional deficits.

Behavioral Observations: Elaine is now 43 years old, and looks older, with short, greying hair. Her gait and voice are a little odd, but not clearly suggestive of either mental illness or mental retardation. Elaine had been tried on Depakote recently, and most staff felt it had reduced her lability and outbursts. She was still tending, however, to keep to herself, and while she could put on a front of cheerful conversation for a minute or two, evidence of continued depression would break in. She repeatedly voiced a number of delusional themes, never bizarre in quality, but rather indicating conflict implicit in her needs and the results she fears if she tries to meet those needs. She said a male staff person was trying to sexually exploit her and other female patients, but then obliquely admitted her fondness for him, followed by an

observation that he was happily married with children and so was unavailable. She claimed her mother was out in the lobby, waiting to visit her, but that staff were pretending it was not so. She clearly wished her mother would visit more often, was angry at her for not doing so, but had to displace anger onto the staff because she knows her mother visits fairly often, and she dares not express her anger directly for fear of abandonment. She said she was very worried that Sue Jamison (The Protection and Advocacy lawyer) was going to sue her mother. She said she had HIV. These delusions came up and were dealt with during the first of three testing sessions. Elaine tried to cooperate with testing, but was hindered both by her general discouragement and by interference by delusional thinking. There were a few instances where she appeared to hallucinate also, but again what she thought she heard was not bizarre, being instead related to her wishes and delusions.

Test Results: Following are the Standard Age Scores (SAS) for the Stanford-Binet cognitive areas, and the overall or Composite SAS. These scores are the same as deviation IQ scores, having an expected mean of 100. However, the standard deviation is 16 rather than the usual 15 (as on the Wechsler tests) so that, for example, 68 rather than 70 is the demarcation line between borderline and mild mental deficiency.

Verbal Reas.	45	Abstract/Visual	54	Quantitative	62	Short Term Mem.	43	Composite	44

Note that the Composite SAS is not an average of the area SAS scores, but represents the extent to which the sum of those scores differs from the sums for the reference population.

Below are the Standard Age Scores for the individual subtests. Only those subtests are listed which are feasible for at least some mildly and moderately retarded subjects. Subtests followed by blanks were not given. While some of these subtests might have been within her capability, I saw no point in piling up additional low scores which were partly attributable to delusional thinking rather than to essential cognitive limitations. The letters nb indicate that a formal basal was not achieved, though she did pass 3 out of 4 of the easiest items.

Vocabulary	24	Pattern Anal.	27	Quantitative	31	Bead Memory	__
Comprehension	26	Copying	__	Number Series	__	Sentence Mem.	24
Vis. Absurd.	18(nb)	Matrices	__			Digit Memory	27(nb)
						Object Memory	__

The subtest SAS scores are based on an expected mean of 50 and a standard deviation of 8. When an area SAS is derived from only one subtest, the effect in retarded subjects is to obtain a somewhat higher score than is likely to result when more subtests are given. I would have liked to give more subtests, but it was clear that Elaine's reasoning powers were occluded by her depression and delusional thinking, and there is no merit in piling up more subtest results if the subject cannot perform at her best. While limited, the results are consistent with the hypothesis that Elaine is functioning at present in the upper portion of the moderate range of intellectual deficiency.

The score for Visual Absurdities was not included in calculating the overall scores, in part because this subtest is usually not given to adults, but also because Elaine's mental disorder seemed to be interfering with this task much more than it had with other tasks. For example, she did not see anything wrong with a picture of a bicycle with square wheels. Confronted with a picture of a blindfolded man holding a newspaper as if to read it, she at first said just, "blind." Pressed for what she meant, she said, "I could go blind." Presented with a picture of a bald-headed man trying to comb non-existent hair, she said, "Holdin' his hand like that--- a bird, that's it! Like you're signalin' like you want to have sex." The examiner pointed out that the man was not extending his middle finger to make a "bird," but Elaine maintained that he was. If the Absurdities subtest score had been included in scoring, the Verbal Reasoning SAS would drop from 45 to 38, and the Composite SAS would drop from 44 to 42. This illustrates the magnitude which Elaine's mental disorder can have on her cognitive functioning.

While not always reflected in the test results, there is a discrepancy between Elaine's surface verbal facility and her marked weakness in both verbal and nonverbal reasoning. Several examiners have commented that she talks as if she is much smarter than she is. I have seen this pattern in some other mental retardates. It seems to occur more often in patients who, like Elaine, contracted meningitis/encephalitis early in life. I do not believe that there is a verbal/nonverbal discrepancy in Elaine's case, but that initial impressions, and certain tests such as the Wechsler verbal subtests, tend to overestimate her verbal ability. This has led many to expect too much of Elaine.

Discussion: Four issues were advanced in a recent peer review of Elaine Wilson's situation. These are related in part to allegations made by Protection and Advocacy, and in part to responses from consulting staff at DLC. They are as follows.

1. P&A expresses concern that Elaine's condition has deteriorated over the years because she has not been receiving minimally adequate services at the hospital.

2. P&A suggests that this is not the least restrictive environment available to Elaine, and that some sort of supervised community placement may be available.
3. There is a question as to whether Elaine's habilitation needs have been addressed.
4. A question was raised as to whether we have an accurate diagnosis.

Taking the last question first, it is quite clear that Elaine is mentally retarded, has a longstanding personality disorder with borderline features, and also has a fairly long history of non-bizarre delusions and hallucinations which serve mainly to express her hopes and fears. These are not just daydreams, but are accompanied at times by very clear evidence of perceptual distortion and disordered thinking. (See examples in this evaluation.)

One possibility would be to diagnose Borderline Personality Disorder on Axis II, along with mental retardation, but to diagnose Schizoaffective Disorder, Depressed Type on Axis I. When patients with Borderline Personality slip over into psychosis, they often present as schizoaffective. Because borderline personality dynamics were present in Elaines's childhood, diagnoses of both Borderline PD and schizoaffective disorder are permissible. However, there is a problem in diagnosing schizoaffective disorder in a patient where there is an Axis III organic etiology, namely encephalitis.

An alternative, which I prefer, is to diagnose Organic Personality Syndrome. There is a clear organic etiology, the same encephalitis which produced Elaine's mental retardation. This diagnosis also permits some degree of delusions and hallucinosis, as well as encompassing disordered mood, affect, and impulsivity such as we see in Elaine. It is not unusual in cases of Organic Personality Syndrome to see prominent borderline personality disorder dynamics. The only problem with this course of action is that Organic Personality Syndrome is in DSM-III-R, but not in DSM-IV. For DSM-IV the diagnosis would be, "Personality Change Due to and Axis III Condition," namely, status post encephalitis with mental retardation. One would then need separate diagnoses of hallucinosis and delusional disorder due to an Axis III condition.

I cannot agree with the idea that Elaine merely has behavior problems related to personality disorder and mental retardation. There is no precedent in either mental retardation or in the study of personality disorders to encompass Elaine's degree of psychosis under these diagnostic umbrellas. It is true that Elaine has in the past made suicidal gestures with the expressed intent of getting into the hospital. It may be true that some of her current delusional and hallucinatory behavior is for attention seeking. But close observation indicates that most of this is not "acting up," it is "acting out" of inner wishes and conflicts. Thus it is not consistently affected by whether others attend to or ignore Elaine's behavior.

The next question concerns whether Elaine's condition has deteriorated, and in what way. The IQ scores have not changed that much. In the table below are shown test scores obtained between 1966 and the present.

Setting/ examiner		Gracewood 66-69		GRHA 1987		Dr. Kaufman, 1995		Dr. DeBacher, 1995
WISC or WAIS	VIQ	WISC	75	WAIS-R	69	WAIS-R	66	
	PIQ		51		66		56	
	FSIQ		60		66		58	
PPVT/PPVT-R			54,57				44	
TONI-2							63	
Vineland							31	
Slosson			48					
Stanford-Binet 4th Edition Composite Standard Age Score								44

These are all "IQ" or Standard Age Scores. Taken at face value, they do not make a strong case for cognitive deterioration. The Wechsler Verbal IQ appears to drop only 9 points. The similar drop in PPVT-R scores is in part due to restandardization. The Slosson IQ of 48 and the Stanford-Binet SAS of 44 are not significantly different. The discrepancy between the WISC/WAIS-R and the other "IQ" scores is also explainable: Wechsler tests are notorious at this hospital for overestimating the IQ of mentally deficient patients. Wechsler himself stated that he never intended for these tests to be used to scale the abilities of individuals outside the normal range (70-130) of intelligence.

It is perhaps in comparing the 1987 and 1995 WAIS-R performances that we see evidence of declining performance. I back-calculated raw scores from the WAIS-R scaled scores reported by Dr. Kaufman, and then compared raw scores and scaled scores

for age (the 35-44 age range). The decrement in the Performance subtests is significant, but is hard to interpret because as Dr. Kaufman pointed out, Elaine essentially did not attempt three subtests, Picture Completion, Block Design, and Digit Symbol, on which she had performed at a mildly deficient level in 1987. On the remaining Performance subtests, her performance did not change at all on Picture arrangement (where she passed only the first item on the 2nd try on both occasions), while there was a drop by about half in her raw score on Object Assembly (14 to about 7). Clearly her failure to make a meaningful attempt at three subtests in 1995 leaves the Performance subtests meaningless as a measure of possible dementia.

For the Verbal subtests, the scaled and raw scores for Information and Vocabulary were unchanged over the 8 year interval. The scaled scores for Digit Span and Comprehension dropped by just one point, and the scaled score for Similarities rose a point. The only significant drop was in the Arithmetic subtest, where both the raw and scaled score dropped from 5 to 2.

The WAIS-R subtests Information, Vocabulary and Comprehension were repeated as part of this evaluation by the present examiner, in order to look for qualitative changes from the 1987 evaluation. Elaine passed only three Information items, the same ones she passed in 1987. She failed 2 Vocabulary items for which she had received full or partial credit in 1987. In one case the failure seemed to be "psychodynamic," when she replied to repair by saying, "To repair somethin' in your life that's not reality." She would not give a scorable elaboration. On Comprehension she failed 5 items for which she had gotten some credit in 1987. In two cases she appeared to be rejecting the question. Her remaining answers were somewhat loose and tangential. The drop in Comprehension score appears due to lower motivation and to exacerbated mental illness, not to any clear dementing process.

In the early 1990s, Elaine's mother became increasingly concerned that Elaine was worsening. She perceived the problem not as dementia, but as markedly increased "paranoia." It got so that the mother could not take Elaine home for a weekend pass without Elaine becoming quite delusional over police surrounding the apartment, or similar concerns. With the increased delusions came longer periods of agitation, with verbal and sometimes physical aggression. The mother also noted that Elaine was discouraged and depressed more of the time.

In reviewing all available records going back to her early teens, it appears that Elaine has always had some delusions and some hallucinatory behavior, and has always had periods of loud agitation, with verbal and sometimes physical aggression. She has always had periods of depression, with reclusive behavior and occasional suicidal gestures. In between these behaviors, she has often been, "...mostly easy going and pleasant when she is busy and with people, and things are going pretty much her own way." She still has patches of good behavior, but they don't last long. The change has been one of proportion rather than of nature: formerly the "good" behaviors predominated, where today the "bad" behaviors occupy much more of her waking hours. Lesley Slone, who has worked at the hopital for over 14 years and worked with Elaine in 1981, is strongly of the opinion that Elaine was doing much better then than she is now.

Why has this change occurred? One can blame "institutionalization" to some extent. One can hypothesize age-related worsening of Elaine's lifelong disorder of mood, affect, and impulse. One can note that Elaine's life has gone very badly, and that she has worn out her already very limited coping skills and resources trying to solve her problems. Quite possibly these factors are all operating together in a destructive synergy.

While I believe Elaine's deterioration is related to "functional" causes, environmental, psychodynamic, and depressive in nature, her loss of weight and her bowel and bladder incontinence must be viewed with concern. They may be due in large part to depression and regression, but she must be watched for signs of CNS malfunction contributing to these problems. There have also been some balance problems, but these appear to have been due to trials of medications such as Tegretol which can cause ataxia.

I think that the hospital services provided to Elaine have been "minimally adequate," in that they have worked to an acceptable degree with other "dual diagnosis" patients who are both mentally ill and mentally retarded. Elaine has generally been stabilized in the past, and was returned to environments which were adequately safe, and in which her basic needs were provided. I think that what has been lacking has been not so much special habilitation services for mental retardation, but rather the lack of adequate holding and growth environments for her borderline personality condition. What services might have made a difference?

It has been suggested that Elaine and her mother need therapy to work on their relationship, and even that Elaine should move back with her mother in order to alleviate her abandonment depression. Elaine's mother, who in my view has much more common sense and compassion than she has been given creit for, has quite properly objected to taking Elaine back, pointing out that Elaine cannot even get through a weekend pass without decompensating. The mother notes that mental health professionals have been telling her for three decades to separate from Elaine, and that reversing course makes no sense. As for "relationship therapy," I do not see how it applies. I have watched them during visits, and the mother relates appropriately. Elaine often relates appropriately as well. If what is meant is the "underlying relationship" (whatever that is), does one embark on serious relationship therapy for a low functioning patient with borderline personality and fluctuating psychosis? I would not wear the mother out on this doubtful enterprise. The problem is not to help Elaine

relate to and live with her mother. The problem is to help Elaine stop living in the turmoil of her wants and fears, to accept her present situation as a starting point, to make use of her pleasanter personality traits, and to learn to live in the community, enjoying life as much as she can.

The possibility of social skills training has been raised. Actually, Elaine has fairly good social skills, when she makes use of them. I have been very impressed at how she can politely and graciously stop me in the hall and raise concerns about her situation without any initial agitation. (That comes later.) It is not her social methods and tactics which are at issue, but her strategy and goals. I would not spend time on social skills unless she is used in a group where she might get some satisfaction by demonstrating social skills for other patients. One area I might cite as an exception would be helping Elaine to find better ways of expressing dissatisfaction than shouting racial epithets at staff and patients. She needs to learn constructive complaining.

It has been suggested that we set up a behavior modification program for Elaine, including rewards for appropriate behavior and for refraining from inappapropriate behavior; and perhaps deduction of tokens or delay of special privileges for markedly inappapropriate behavior. I do not anticipate more than limited success with this approach. Because of her depression, Elaine has reduced interest in tangible or social rewards. She is likely to perceive the structure of a behavior modification program as just another imposition on her misery. She might, however, be reinforced by periods of quality time and conversation with staff, provided that deprivation of such time is seen as a natural and logical consequence for closely related inappropriate behavior, and not as a penalty for such things as getting out of bed late or reluctance to bathe.

The general outlines of a treatment and placement program are perhaps seen in Extended State Hospital Treatment of Severely Impaired Borderline Patients by Drum and Lavigne (Hospital and Community Psychiatry, Vol.38, pp 515-519, 1987). They discuss the establishment of an adequate holding environment in the hospital, the maintenance of that environment to foster limited changes in the patient, and the transfer of the holding environment from the hospital to the community. It appears that we have been trying to do what they suggest in our history of management with Elaine. Often the hospital has functioned well for Elaine as a basic holding environment, but we have been less successful in fostering change, and we have had great difficulty finding community placements where the necessary extension of the holding environment can be realized.

Elaine has become so worn out in this environment that she would benefit from a complete change of scene to help her climb out of her depression and take renewed interest in life. Our hospital was never intended for long-term habilitation (except DLC which serves lower functioning retardates), and our relatively spartan physical and social environment is intended to inspire patients to return quickly to life outside. It is unavoidably lacking as a long-term growth environment. Elaine may need a new and more giving environment. Perhaps this could be found eventually in a structured community residential program for relatively high level mentally retarded patients, a program able to deal with serious behavioral and emotional problems. If Elaine is not ready for such a community placement, then she might do better in an upper level rehabilitation program at one of the state mental retardation hospitals.

We have discussed the matters of diagnosis, of habilitation needs, of minimally adequate services and of the least restrictve environmental options. The peer review also included a number of recommendations concerning assessment, treatment, and placement. I hope it is clear that more assessment is not a priority; we have workable diagnoses and can specify relevant treatment options. Brook Run should be asked to assess this patient only if the purpose is to determine whether she enters the state MR system. While an outside MR consultant's assistance would be welcome, it is not strictly necessary, because both the current behavior specialist on Treatment Unit and her supervisor (me) have training and experience in the area of mental retardation.

It was recommended that Elaine's psychiatric condition be better stabilized. It is unfortunate that neuroleptics have not been more helpful with her delusional and hallucinatory behavior. We might view these behaviors as psychotic features accompanying depression. If this is true, then relief of depression may reduce psychotic symptoms. As for her disruptive behavior, Depakote was tried recently, and may have left her less labile and agitated. She has received only a brief and inconclusive trial with an SSRI, so Zoloft or a similar medication could be tried for relief of depression. SSRIs sometimes contribute to reduced lability in borderline patients.

I have noted already that behavior modification and social skills training may have limited promise. A recommendation to establish a Foster Grandparent or similar relationship to allow daily interaction with a trusted person is worth trying, but may hold hazards for a patient with borderline personality dynamics. It will be necessary for all the staff to attempt a more actively friendly and nurturing relationship with Elaine. She needs to be coaxed into more pleasant activites. When she is delusional, staff should avoid reinforcing this behavior with too much attention, but it has been useful to gently counsel with Elaine to correct her delusional ideas and to help her clarify her feelings. If she escalates into a tirade, she should be ignored as much as possible, or quietly and matter-of-factly informed if natural or logical consequences must be applied because of the needs of the situation. If she is being reclusive and negative, she should not be chided or

harassed, but should be quietly informed if essential procedures are required. She should be given real choices as much as possible. When she is in a relatively good mood, staff can again offer options for pleasant activities. Staff should not wait to offer diversions and options until Elaine behaves badly. This can have the effect of reinforcing inappropriate behaviors.

If it were administratively possible, we might move Elaine from Treatment Unit to a temporary "apartment" in a spare room on DLC. We could then schedule activities for her at the Gift Shop or in VR, as well as remedial educational activities to restore her basic reading activity and to increase independent living skills. She would continue to receive individual counseling and relevant group experiences through Treatment Unit. Later she could bus off campus to attend relevant day programs. I would not recommend any of these steps without first explaining to Elaine what was intended and getting her consent, as well as indicating what must happen if the placement fails. I would also hesitate to take such steps unless some very strong options for eventual outside placement had been identified and researched. While I am anxious to see Elaine in any environment which works better for her, I do not want an intra hospital transfer which might not lead anywhere.

Summary and Recommendations: Elaine Wilson is a mentally retarded patient with borderline personality structure and with mood, hallucinatory, and delusional symptoms consistent with Schizoaffective Disorder, Depressed Type. Her disorder can also be regarded as Organic Personality Syndrome with borderline personality traits and depression. Elaine's speech misleads others into thinking that she is no worse than borderline IQ or mildly retarded, but she is in the upper portion of the moderately retarded range on the more appropriate tests. There does not appear to be clear evidence of organic deterioration, but depression and related delusional and hallucinatory symptoms are interfering with cognitive function. She should be watched, however, for any indication of a structural organic condition contributing to her current difficulties.

Elaine's behavioral problems appear mainly related to her borderline personality structure and to her depression, and not to insufficient habilitation with respect to her mental retardation. If Elaine could act through the whole day as she does at her best, her deficiencies in social and ADL skills would be of little consequence. Therefore alleviation of her problems will come not through the mechanical provision of behavior modification and skills training, but through alleviation of depression and through provision of a more pleasant and giving environment in which she can be helped to relate to others in a less regressive manner.

A minimum goal would be to achieve some relief of depression through pharmacology, and to improvise a more caring and giving environment on Treatment Unit. Placing her in a new environment, however, might provide the contrast needed to help her break her current patterns. She will probably require a closed, inpatient environment in the near term, but there is some consensus that she could eventually achieve community placement. I would favor placement in a professionally supervised group home for higher level patients with mental deficiency and mental illness.

Gary DeBacher Ph.D., licensed clinical psychologist

chart that you're looking at?

A Yes.

Q What does that note say? You can summarize it.

A Okay. It says that I was assigned to work with her on 9-18-95.

Q Now, with reference to the progress notes if that would help, could you indicate what you were doing with regard to placement efforts at that time? If you were doing things in the area of placement, would it be reflected in the progress notes?

Let me just ask that question again before we start paging through, because I know you need to look for your entries in there. If you were working in the area of placement, would you write it in the progress notes?

A Yes.

Q So now if you could just glance at the notes to see if there was any activity, I'd appreciate it.

A This note does not address placement. This was my first contact with her.

Q Do you have any memory at all of doing any activities for E.W. in the area of placement, identifying placement for her?

EXHIBIT 13 (3p)

specifically?

A Yes. But I don't remember the person that I talked to, her name.

Q You left a message for her to call back?

A Yes.

Q Did she call back?

A Yes. We, you know, phone tagged. She missed me and et cetera, but yes, she did.

Q When you first called, even though you had to leave a message, was that right after you got back from sick leave when you called the Regional Board?

A I don't remember, you know, about it being my first day back.

Q Can you remember if it was shortly after you got back?

A Yes.

Q And can you remember when you and Mrs. Sheppard finally stopped playing phone tag, when you actually spoke with her, when that was?

A I don't remember the date.

Q Not the exact date, Ms. Ligon, of course.

A Sometime in February, I guess.

Q Okay. So it took from November '95 until February before you were able to hook up with the persons who provide mental retardation services?

A Yes, that's right, to get in contact with them.

Q All right. Now, you actually finally spoke to Mrs. Sheppard, is that right, on the phone?

A Yes.

Q Can you recall that conversation?

A Yes. I remember it.

Q Tell us what you remember about that conversation.

A I gave her the name, told her I wanted to make a referral, asked her to come out and evaluate her. She agreed to do that.

Q Okay. Has that occurred yet?

A No.

Q Has that been scheduled?

A Yes, it's scheduled.

Q What is the date, please?

A The it's set up for next Monday at 10:00 o'clock, the 18th.

Q Bess, Ms. Ligon, the thing that's confusing me here, I thought you knew about this evaluation process right from L.C.'s case, that the Regional Board does the evaluation. Didn't they do that in L.C.'s case?

A Yes, they did.

Q Did you think she could be supported in the community at the time of that April 21st meeting?

A I think that she -- that more needed to be done at that time; that even if the ideal placement had been available, I would have wanted to see some very careful preparatory planning and maybe some trial visits in order to enlist her opinion and her reaction and to work some things through.

Q Uh-huh. (Affirmative.) Certainly she was interested in being place in the community, wasn't she?

A That was hard to judge from her behavior. I think that there was a period when she was so depressed that she was actually resisting going out of the hospital. And she has an older record of deliberately doing things to come back the hospital. So that I suppose she was ambivale

Q Most of her prior placements have personal care homes where she would come back to the hospital, correct?

A (Nods head affirmatively.)

Q And those have relatively little support for a person with her needs?

A Yeah.

EXHIBIT 14 (40)

Q I guess in theory, though, they are the people out there providing that back up in some instances; is that true?

A I'm not sufficiently familiar with that. I don't know whether the division is capable of providing any back up directly or I don't know if there are any grant supported or other types of program that can provide it in the community. I would think that private companies could provide it if the funding were available.

Q Assuming a group home placement like this was available, what kind of time period were you thinking about from this April meeting to where EW should have been ready to go to a group home like this?

A I don't think I really know that. I wouldn't want to speculate on that. It would have helped us to have a specific group home to plan for. It helps if you have a target where you can go and look at the situation and talk to the people and say what do you need for this person to be able to live with you.

Q Have you treated people like EW in the past?

A Generically, people with, you know,

like to have seen that empirical question answered myself. I would have liked to see her tried in a home like that to see what would happen. But I'm not -- I can't say that definitely that it would have worked. I regard this as a pretty severe case.

Q If you had a home provider who said they would be willing to take her, do you think it would be a good idea to give her a try in the community?

A You mean a staffed group home or just an individual provider?

Q A staffed group home that can provide the things you indicated a group home should do.

A Sure, yeah.

Q At what point do you think it would have been good to try that?

A Well, as soon as we would have known about such a place and had maybe about a month to prepare to, you know, based on her current situation and let her see the place; let them get to know her; talk about contingencies; trial visit her there for a while; you know, give her some encouragement for doing okay.

Q Okay, so any time with a month lead time or so after that April meeting, if you had known

about a placement --

A Not after the April meeting. I think maybe -- I think it's conceivable that later on there were times when we could have -- with a month's lead time, we could have planned and tried that.

Q By the end of the Summer?

A Yeah.

Q The report that you made, you still have a copy of that, I take it, on EW?

A (Nods head affirmatively.)

MS. DOWNING: Let me just say that's been produced.

MR. BLISS: That has been produced?

MS. DOWNING: Yeah.

MR. BLISS: Okay, I haven't seen it. I'll have to look around for it.

MS. DOWNING: His file was produced. Let me say too, the report also contains some peer review in it so there was some basis for his confusion about, you know, whether it was attorney/client or not. And some/attorney clients things were in it; and the decision was made that since most of it was not, to go ahead and produce it. So that was produced.

MR. BLISS: Okay, I don't think I have

JUNE KAUFMAN, PH.D.
LICENSED PSYCHOLOGIST
PRACTICE IN CLINICAL PSYCHOLOGY

1214 CLAIRMONT ROAD
SUITE 100
DECATUR, GEORGIA 30030
(404) 321-6206

DEVELOPMENTAL DISABILITIES & GERIATRICS
INDIVIDUAL, CHILD, MARITAL
AND FAMILY THERAPY

PSYCHOLOGICAL EVALUATION

NAME: ELAINE WILSON
ADDRESS: GEORGIA REGIONAL HOSPITAL
DOB: 09-13-51
AGE: 43 YEARS
DATE OF EVALUATION: 04-06-95
PLACE OF EVALUATION: GEORGIA REGIONAL HOSPITAL
EXAMINER: JUNE KAUFMAN, PH.D.

REFERRAL AND BACKGROUND INFORMATION

Elaine was referred for a psychological evaluation by her attorney Ms. Sue Jamison in order to assist in determining an appropriate placement for Elaine who is about to be discharged from Georgia Regional Hospital. Elaine has a history of mental retardation and behavior problems. Elaine's mental retardation was attributable to brain damage secondary to a high fever in an illness at age one. Her developmental milestones were all delayed. At age 15, she was admitted to Gracewood, a facility for the mentally retarded, because of severe behavior problems. According to her Gracewood medical records, Elaine's behavior problems were considered to be "secondary to brain damage".

While at Gracewood, Elaine was evaluated and found to be functioning in the top portion of the Moderate range of Mental Retardation on the Wechsler Intelligence Scale for Children(WISC). Also, her vocabulary skills were at a six year level, as measured by the Peabody Picture Vocabulary Test. The evaluator commented that given her intellectual limitations, Elaine " demonstrated sensible, logical thinking.. and could perform best in a position whereby she were not placed under very much stress". Furthermore,she added that Elaine" needs much encouragement and will not be able to function in a situation in which she receives very much criticism". In recent years, according to her mother, Mrs. Jackie Edelstein, Elaine has received the diagnosis of paranoid schizophrenia; and despite antipsychotic medication, she has become increasingly paranoid and dysfunctional. Elaine has been in many personal care homes which she has left due to her severe behavior problems. Both her attorney, Ms. Jamison, and Elaine's mother expressed the opinion that the placements have been inappropriate for a woman with mental retardation and behavior problems.

METHODS USED

REVIEW OF SCHOOL RECORDS
INTERVIEWS WITH MS. WILSON AND MS. EDELSTEIN (MOTHER)

EXHIBIT 15 (4 p)

Elaine Wilson

TESTS

WECHSLER ADULT INTELLIGENCE SCALE- REVISED (WAIS-R)
TEST OF NONVERBAL INTELLIGENCE-2 (TONI-2)
PEABODY PICTURE VOCABULARY TEST- REVISED (PPVT-R)
WIDE RANGE ACHIEVEMENT TEST-3 (WRAT-3)
PEABODY INDIVIDUAL ACHIEVEMENT TEST- REVISED
(PIAT-R)
VINELAND ADAPTIVE BEHAVIOR SCALES, SURVEY FORM
(INFORMANT: MRS. EDELSTEIN, MOTHER)
DRAWINGS

BEHAVIORAL OBSERVATIONS

Elaine presented as an agitated and frightened woman, who needed considerable reassurance to calm down and cooperate with the testing. Her visual acuity appeared impaired at times, but informal testing revealed that it was adequate for test purposes. However, when possible, such as on reading tests, letters were enlarged to ensure valid results. Periodically, Elaine became distracted and talked in a paranoid manner about the staff disliking her and picking on her. When asked why she recently tore up a group of plants from the ground, Elaine replied " I was angry with them.. that's why I did it". Elaine became more upset when she did not comprehend questions or perceived that tasks were too hard for her. However, she was frank and open about her disabilities and stated " I can't really read or count". Importantly, Elaine's conversational skills were well-developed thereby giving the impression of a higher functioning individual than was actually the case.

TEST RESULTS AND INTERPRETATION

VINELAND

Domain	Standard Score	Age Equivalent
Communication	30	6-7
Daily Living Skills	51	8-0
Socialization	20	3-11

Adaptive Behavior Composite = 31

WAIS-R

Verbal IQ= 66
Performance IQ=56**
Full Scale IQ= 58

Elaine Wilson

Verbal Tests	Scaled Score*
Information	2
Digit Span	5
Vocabulary	4
Arithmetic	2
Comprehension	3
Similarities	5

Performance Tests	Scaled Score**
Picture Completion	1 (No responses)**
Picture Arrangement	2
Block Design	1 (No responses)**
Object Assembly	2
Digit Symbol	1 (No responses)**

* Mean of each subtest = 10, standard deviation = +/-3
Scores between 7 & 13 are in the average range

** Although no scoreable responses were given, the minimum score on each subtest is 1.

TONI-2

Nonverbal IQ 63 (1st. percentile)

WRAT-3

	Grade Equivalent	Standard Score
Reading Recognition	3	58
Arithmetic	1	Below 45

PPVT-R

Receptive one word vocabulary age = 4-10
Standard Score = 44, Percentile = 1

PIAT-R

Reading Comprehension = 1.5 grade level

Elaine obtained a Full Scale IQ of 58 on the WAIS-R, placing her overall intelligence in the bottom portion of the Mild range of mental Retardation. However, this score was spuriously inflated by Elaine's failure to perform a few subtests within the Performance

Tests domain. because of the psychometric properties of this test, she still receives a basal score of 1 and not 0 even though there were no scoreable responses. Thus, in this examiner's opinion her true functioning is probably in the top portion of the Moderate range of Mental Retardation. Along these lines, her estimated age from a human drawing was 4 1/2 to 5 years. Comparing her scores with her prior evaluation indicated possible deterioration in her functioning although different measures were used. On the WAIS-R, Elaine's verbal skills were noticeably better developed than her visual/visual-spatial skills. However, she obtained an IQ score of 63 on the TONI-2, placing her nonverbal problems solving skills in the Mild range of mental retardation. her score on the TONI-2, was probably higher than her WAIS_R Performance IQ score since the former is not only language-free and culture-fair but motor-free as well.

Elaine's vocabulary skills as measured on the PPVT-R, were grossly delayed, and below the level expected on the basis of her verbal IQ scores. Thus, not surprisingly, Elaine had poor decoding skills(third grade level), and virtually rudimentary reading comprehension skills as measured on the PIAT-R.

On the Vineland. with her mother serving as the informant, Elaine obtained an adaptive behavior composite of 31 indicating severe delays in her overall adaptive functioning. Her daily living skills constituted her strongest area; and her socialization skills represented her weakest area. Elaine has mastered basic self-care skills but can not tell time by five minute segments, can not cook or correctly count change from one dollar. She does no domestic chores including cooking or work activities, and does not look after her own health. Elaine is a loner, has no friends and does not follow community rules. She does not end conversations appropriately and does not control her hurt or angry feelings. Furthermore, she is suffering from severe paranoia, and is often verbally aggressive. Ms. Edelstein expressed concern that Elaine's agitated and paranoid behaviors had worsened during her present stay at Georgia Regional.'

SUMMARY AND RECOMMENDATIONS

Elaine is a patient at Georgia Regional Hospital who has been diagnosed with paranoid schizophrenia and is about to be discharged into a community group home. However, she has a history of mental retardation; and on this evaluation, she was found to be functioning in the Mild to Moderate range of Mental Retardation along with rudimentary academic skills and severe deficits in her adaptive functioning. If she is discharged from Georgia Regional she needs to have a highly structured residential home appropriate for an individual with mental retardation and behavioral/emotional deficits. She also needs to be involved in a sheltered workshop program appropriate for a mentally retarded individual who has been institutionalized many times due to possible inappropriate placements.

June Kaufman, Ph.D.
Licensed Psychologist

you asked whether we had had any meetings related to dual diagnosed clients; is that right?

Q Yes.

A Is that right?

Q Yes.

A Taking that as a general question, that's why I responded probably we have. But in terms of specific clients, I do not recall -- I can't remember a specific case is what I'm trying to say to you.

Q Okay, thank you. And correct me if I'm wrong about this: Is it -- you have no memory of any particular training courses involving mental health and mental retardation?

A Not specific; not specific, no.

Q Okay. And you -- do you recall ar courses that your social workers have taken or th you have taken specifically related to the habilitation or training of mentally retarded patients?

A No.

Q Do you work, Ms. Thornton, with the access team or are you familiar with the access team?

A I am familiar with the access team.

Q Can you describe it just briefly,

EXHIBIT 16 (2 p)

please?

A It is nearly two years old. It is a community-based outreach program begun out of Georgia Regional. It's made up of teams consisting of social work -- or human service provider tech staff, RN's, peer consumers involved, led day to day by Shirley Hamilton. It began by identifying a group of patients as of two years ago that had four or more hospitalizations, and decided to focus on that group because they spend -- you spend a great deal of energy for people who are here a lot of times. I don't know exactly how many they have served, but it was to do intensive -- very intensive -- case management and consumer orchestration seven days a week, 24 hours a day.

Q You explained that that was to deal with patients who are readmitted frequently; is that correct?

A It was a certain number as of that date. It was -- at that point in time, it was a certain -- there was a certain list of names. It was a specific group. I think they've certainly added to that group since that time.

Q Is it correct that those individuals who are readmitted on a regular basis were in need of

Draft 10/5/95

ACCESS TREATMENT PLAN

* Please note that the services described on this plan are contingent on the receipt of funding and clinical condition which is subject to change thourgh on-going assessments.

Name	Lois Curtis	Treatment Plan Date:	Effective upon discharge from Brook Run
DOB	7/14/67	Next Review Date:	6 MONTHS
SSN	[redacted]		
Enroll	6/30/95		

STRENGTHS:

Artistic in drawing; has sewing skills, can express her needs verbally; has self care skills; has vocational skills, family is concerned about her well-being.

LONG TERM GOALS:

1. Lois will learn adaptive skills in community living without significant symptomology of auditory hallucinations, delusions or violence which causes hospitalization in excess of 30 days.

2. Lois will be able to function in the community with minimal assistance in vocational, residential and interpersonal or self care for one year.

DIAGNOSIS:

Axis I: 298.9 - Psychotic disorder NOS, R/O Schizoaffective Disorder

Axis II: 317/318.0 - Mental retardation, mild to moderate

Axis III: Pseudoseizures, R/O seizure disorder

Axis IV: Moderate to severe secondary to prolonged hospitalizations

Axis V: GAF = 10 Current (Persistent danger of hurting self and/or others and grossly impaired socialization) : current

EXHIBIT 17 (9p)

Focus Area PSYCHIATRIC

Focus Area

Lois is a 28 year old black woman who has been diagnosed with a psychotic illness and mental retardation since childhood. She has a history of sexual promiscuity with poor judgment about birth control and diseases. She has been hospitalized for approximately 12 of the last 14 years at numerous hospitals including Georgia Regional Hospital/Atlanta, Georgia Mental Health Institute, Grady Hospital, Central State Hospital, and Brook Run. At age six she was seen at South Central Mental Health Center for aggressive and threatening behavior. Her grandmother reported that Lois began complaining of "hearing voices" at age seven or eight. She was hospitalized at age eight for destruction of property and attempting to choke her younger sister. Though she was noted to be psychotic on several of her many admissions, the primary reason for admissions seemed to be behavioral problems, mainly violence or threats of violence towards others along with less common suicide attempts. In 1988 she received three years of probation for knifing her sister and one year later went to prison and then to Central State Forensics Unit for breaking probation. Community placement failed over and over due to her threatening and violent behavior.

Three years ago she was hospitalized at GRH/A for threatening her supervisor at work with a knife. She was diagnosed as being psychotic when admitted. The psychotic symptoms were thought to be cleared over the next year and half, but she continued to periodically attack others without provocation. She was released two months ago but was re-hospitalized at Brook Run after her mother was no longer able to keep her at home. Her most flagrant symptoms and problems at Brook Run are hallucinations, delusions and episodes of violent behavior. Continued stabilization of clinical and behavioral condition is needed prior to completion of discharge planning. Her violence is thought to be secondary to her psychotic symptoms and to long standing behavioral habits. Her sexual promiscuity has not been a problem at Brook Run, presumably due to the close monitoring.

While at Brook Run, Lois received psychological testing. Verbal IQ = 54, performance IQ = 65, full-scale IQ = 57. The Vineland adaptive behavior scale was also conducted with the findings showing Ms. Curtis adaptive functioning being equivalent to four years and ten months of age. Current medication consist of Haldol, Deconate 200mg, Tegratol 200mg by mouth twice a day.

Long Term Goal

1. Lois will be able to live semi-independently without interference from psychiatric symptoms (e.g., hallucinations, delusions) for one year.

Short Term Goal

1. Lois will comply with psychotropic medication regimen as prescribed for six months.

2. Lois will be able to identify early signs of decompensation and follow a prevention plan for six months.

Intervention

1. The psychiatrist and the Team Coordinator will meet with Lois 2x month for 60 minutes and PRN to assess medication for the first 90 days then a minimum of one time per month for 30 minutes thereafter.

2. The staff psychiatrist will consult with a mental retardation and mental health specialist for on-going assessments and medication regimen.

3. Team I staff will alternate individual sessions with Lois 1x week for 30 min to help her develop her preventive plan through educational discussions of her early signs and alternatives.

Focus Area MEDICAL

Focus Area

Seizures were first noted in the record 10 years ago. Pseudoseizures were identified sometime since then. She was seen by a neurologist, Dr. Bruce Bosse at Brook Run in August 1995, who read a normal EEG, witnessed a pseudoseizure, and could neither confirm nor rule out true seizures. Currently she takes Tegretol and her seizures/pseudoseizure are infrequent.

Long Term Goal

1. Lois seizures will be controlled with medication.

2. Lois will express her needs rather than act out pseudoseizures.

Short Term Goal

1. The nature of true seizures should they occur they will be evaluated.

2. The frequency of pseudoseizures will decrease by 50 percent in the first 90 days.

Intervention

1. ACCESS and residential staff will be trained by the psychiatrist to distinguish true seizures from pseudoseizures.

2. Within one hour of each "seizure", residential and/or ACCESS staff will discuss with Lois circumstances proceeding seizure to help her distinguish any known precipitant.

Focus Area RESIDENTIAL*

Focus Area

Lois was raised by her maternal grandmother from 12 months to eight years of age. They lived in a housing project in Atlanta. Since her first admission to Grady in 1975, she has had multiple psychiatric admissions. Between admissions, Lois usually was discharged back home to her family. In 1991, she was placed in an apartment for one year with live-in staff under the supervision of Project Rescue. However, she had five emergency admissions to GRH/A due to violence and aggression toward staff. She smoked incessantly and had problems following any structure. On the fifth admission in May of 1992, she was hospitalized at GRH for the following three years. In May of 1995, Lois was on trial visit from GRH and was placed at home with her mother and seven year old sister. Her mother had problems managing Lois at home and recognized that she could not provide Lois with the necessary support in her home. Lois has been institutionalized most of her adult life, and it is clearly evident that her severe behavior problems have made it extremely difficult for her to achieve community living.

Long Term Goal

1. Lois will reside in a supportive living arrangement in the community for one year with no psychiatric or behavior related hospitalizations.

Short Term Goal

1. Lois will comply with residential rules and regulations 90 percent of the time for 60 days.

2. Lois will express her feelings and needs in ways other than destroying property or threatening others 90 percent of the time for 60 days.

3. Lois will comply with her daily living activities (i.e., bathing, grooming) with no more than one incidence of noncompliance per week.

Intervention

1. The Team Coordinator will check in with resident manager and other staff when she meets with Lois for her weekly 1:1 session to monitor compliance with house rules and make ongoing assessment of ability to live in semi-independent housing. Will meet with resident manager and other staff at the facility to problem solve any issues 2x monthly.

2. Residential staff will provide 24/7 supervision and teach Lois activities of daily living such as cleaning, laundry, personal hygiene daily.

3. Lois will have day visits with family a minimum of 1x per month will be facilitated. The Team Coordinator will provided family counseling for one hour per month to discuss issues that interfere with Lois' ability to interact appropriately with family and explore solutions.

*The projected residential placement is Nysha Hands, located at 3442 Midway Road, Decatur, GA 30083.
One interview has occurred and L.C. is scheduled to return with her mother.

Focus Area VOCATIONAL/EDUCATIONAL

Focus Area

Lois completed the 10th grade. She attended Stanton and Martin L. King Elementary Schools. She was transferred to South-Metro Psycho-Educational Center from Price High School while in the eight grade due to difficulty processing information. Lois does have some basic educational skills in reading and writing, but they are very limited. She has worked in three vocational rehabilitation facilities. Through community friendship, she worked at Pizza Hut until April of 1992. She threatened her supervisor with a knife thus resulting in hospitalization. During an admission at GRH/A, she worked through the vocational rehab program in the kitchen. She had to be terminated due to trading sexual favors for cigarettes and Cokes. Lois also has worked at Morrison's Cafeteria and was terminated because of telling customer she was from GRH and was delusional. She currently works in a sheltered workshop at Brook Run where she has been able to remain on task; however, she needs constant structure concerning her need for smoke breaks.

Long Term Goal

1. Lois will actively participate in a day program for one year.

Short Term Goal

1. Lois will participate in work adjustment where within 6 months she will learn food preparation and serving. She will learn and develop skills in areas of dependability , getting along with others, personal hygiene, how to stay focused on task.

2. Lois will participate in socialization programs with others where she learn basic friendly conversation skills and how to resolve conflict.

Intervention

1. ACCESS staff will arrange transportation for Lois to attend the day program at Community Friendship Monday - Saturday. The work adjustment coach will teach Lois food preparation and serving 4 days per week 3 - 4 hours per day. The work adjustment coach will teach Lois food preparation and serving. She will be praised when procedures are followed and task completed. She will be encouraged to repeat tasks when incorrect.

2. Community Friendship will engage Lois in the work adjustment and socialization programs.

3. Social club staff will teach Lois basic conversation skills and ways to resolve conflict with others through role play, games, discussions, positive feedback, privileges, etc., 2 days per week 2 hours each day

4. ACCESS staff will reinforce these skills weekly in 1:1 30 minute wrap up session designed to recap weekly experiences.

5. Some evenings and weekend actives will be considered when the residential placement has been established.

Focus Area BEHAVIORAL

Focus Area

Lois has a past history of aggressive, threatening and self mutilation behavior, which has resulted in many hospitalization. At the age of five, Lois was seen as an out-patient client at South Central Mental Health Center for behavioral problems. Past hospitalizations to Georgia Regional Hospital at Atlanta, Georgia Mental Health Institute and Central State Hospital were due not only to psychosis, but also behavioral problems. The behavioral problems consist of attacking her mother with a knife. While in school, she fought with her teacher, attempted to attack others in the community and at home. In 1989, Lois at Central State Forensic Unit, after violating her probation. She was originally arrested for attemption to stab her sister.

Lois has been hospitalized at Brook Run since July 27, 1995. Behavioral data intervals was collected from July 27, 1995 - August 24, 1995. Each interval consist of following staff request; 9 intervals of self-injury; 10 interval of disruptive behavior, i.e., screaming or crying, which interfered with the activities of other; 1 interval of property destruction; 4 intervals of socially offensive behavior, i.e. disrobed in public, voided outside the bathroom or made sexual gestures to others; 2 threats of running away; and 6 intervals of attempted or actual aggression toward others. It is possible that Lois will never be behavioral free. However, with a structured day and a strong support system, it is possible that she will be able to maintain community living.

Long Term Goal

1. Lois will demonstrate an increasing ability to control impulses to harm herself, others or destroy property for one year.

Short Term Goal

1. Lois will report warning signs and feelings that are associated with impulses to harm self, others or destroying property daily x 90 days.

Intervention

1. Team I staff will alternate individual sessions for 30 minutes 2x per month to encourage Lois to talk about early life experiences and other frustrations which precipitate aggression or violent behavior.

2. The existing behavioral management plan will be modified prior to discharge to fit the needs of residential placement and the day program.

3. ACCESS Team I will consult with a behavioral consultant PRN and 1x weekly for behavioral management consultation.

CRISIS INTERVENTION*

ACCESS is a 24/7 hour a day seven days a week mobile crisis project (see attached program description).

The following plan will be executed when it is determined by Nysha Hands** and/or ACCESS staff that Lois' behavior has escalated to the pre-crisis or crisis state.

1. ~~Go to~~ Withdraw to a private area to de-escalate by listening to radio, drawing and reading, or spending quality quiet time alone.
   a). She will monitored by staff at all times during crisis.

   b). All mirrors will be removed since reflection of herself to escalate.

2. Go to the office at the home and take some time to de-escalate and then staff will use verbal intervention
   a). If verbal intervention is needed, the ACCESS On Call person will be contacted and informed of the situation.

3. If she continues to escalate the ACCESS On Call person will be contacted again and the following interventions will be employed.

   a). Dr. Smith will contact Doris at Nyasha Hands and give a verbal order for a PRN.

   b). Or Lois will be removed from the environment and taken to a respite apartment or Person Care Home where ACCESS staff will provide supervision.

   c). Lois will be able to remain at the respite facility between 24 - 48 hours.

4. If Lois is assessed and there is a need for hospitalization, due behavioral problems it is recommended that she be evaluated at Brook Run. If she is exhibiting psychotic symptoms, it is recommended that she be evaluated at Georgia Regional Hospital at Atlanta.

*A similar crisis plan will developed at the day program.

** If a different residential placement is made, this component will be modified.

DRAFT

SERVICES COST PROJECTIONS*

for L.C.

Expenses	FY 96	Annualization
ACCESS:		
Service Coordination:	1717	1701
Assessment:	460	460
Crises Management:	4585	4585
Medication Admin:	239	287
Indv. and Family Counseling	7832	9398
ACCESS Sub-Total	14833	16431
Behavioral Consultation: (Medicaid Clinic Option Family Training/Counseling 10 hrs/mo.)	9128	10954
Psychiatric Consultation: (assumes 8 hrs/mo. first three months; 4 hrs/mo. through June)	4954	2477
Community Programs:		
Day Treatment	6000	7200
Social Club	1800	2160
Sub-Total	7800	9360
Day Habilitation:	5057	6068
Residential Trn. Supv.:	32285	43165
Total EXPENSES:	74057	88455

*These figures will need to be adjusted based on L.C.'s actual needs post discharge Additionally, this does not constitute a guarantee that there will not be unforeseen cost barriers

BUDGET SUMMARY

	FY 96	Annualization
Expense	74057	88455
Revenue (all sources)	74057	88455

DMHMRSA State Cost:

State Match to DMA** (at 38.02%)	14850	19365
ACCESS	13116	14730
Grant in Aid***	4954	2477
Total MHMRSA State Cost	32920	36572

** Source: 7425 from DMHMRSA
7425 from Region 5

*** Source: Region 5 (to be identified)
These funds are not currently available

D-5-4a

L. C. vs Tommy Olmstead

Response to Interrogatory #2

Total amount spent on Community Mental Retardation Services

FY92	FY93	FY94	FY95
92,842,627	95,324,251	92,962,305	96,834,822

Response to Interrogatory #3

Total amount spent on Community Mental Retardation Services by Program.

	FY92	FY93	FY94	FY95
MR Community Assistance	4,783,248	4,869,569	5,156,820	1,895,166
MR Day Habilitation	67,010,549	71,712,855	68,702,397	75,153,273
Foster Grandparents-Senior Companions	720,719	687,670	709,623	741,236
Project Rescue	479,632	516,663	522,184	540,887
Project ARC	372,125	379,214	382,273	444,351
Group Home for Autistic Children	268,956	280,746	284,276	296,263
Community MR Staff	3,772,707	4,052,005	4,112,265	5,024,171
Community MR Residential Services	15,345,918	12,734,629	12,998,866	12,644,003
Clayton Co Board of Education-Autistic Children	88,773	90,900	93,600	95,472
	92,842,627	95,324,251	92,962,304	96,834,822

Response to Interrogatory #4

Total amount spent on Community Mental Health Services

FY92	FY93	FY94	FY95
87,109,948	88,171,570	95,556,987	112,025,305

Response to Interrogatory #5

Total amount spent on Community Mental Health Services by Program.

	FY92	FY93	FY94	FY95
Outdoor Therapy Program	3,139,147	3,356,273	3,549,819	3,660,955
MH Community Assistance	10,393,372	11,510,359	9,694,014	1,885,693
Supportive Living	17,560,717	20,194,017	24,503,632	29,651,896
Community MH Center Service	55,683,230	52,770,633	57,463,510	76,480,077
Project Friendship	333,482	340,288	346,012	356,684
	87,109,948	88,171,570	95,556,987	112,035,305

Response to Interrogatory #6

Total amount spent on Institutional or Hospital Services by Direct Care Units dealing with Mental Retardation.

FY92	FY93	FY94	FY95
72,628,307	77,253,995	78,831,289	80,940,807

EXHIBIT 18 (5P)

Response to Interrogatory #7

Total amount spent on Institutional or Hospital Services by Direct Care Units dealing with Mental Retardation.

	FY92	FY93	FY94	FY95
Southwestern State Hospital	10,363,019	10,868,717	11,044,325	11,476,295
Brook Run	15,251,582	15,539,725	16,027,817	16,239,672
Georgia Mental Health Institute	0	0	0	0
Georgia Regional Hospital at Augusta	0	0	0	0
Northwest Georgia Regional Hospital	3,468,426	3,799,649	3,828,466	3,963,455
Georgia Regional Hospital at Atlanta	2,392,433	2,592,684	2,568,311	2,245,687
Central State Hospital	20,093,500	21,889,243	22,300,534	23,098,297
Georgia Regional Hospital at Savannah	0	0	0	0
Gracewood State School and Hospital	21,059,347	22,563,977	23,061,836	23,917,401
West Central Georgia Regional Hospital	0	0	0	0
	72,628,307	77,253,995	78,831,289	80,940,807

Response to Interrogatory #8

Total amount spent on Institutional or Hospital Services by Direct Care Units dealing with Mental Health.

FY92	FY93	FY94	FY95
112,473,995	120,006,661	125,142,504	131,920,891

Response to Interrogatory #9

Total amount spent on Institutional or Hospital Services by Direct Care Units dealing with Mental Health.

	FY92	FY93	FY94	FY95
Southwestern State Hospital	8,631,584	9,157,069	9,389,370	10,496,919
Brook Run	0	0	0	0
Georgia Mental Health Institute	9,922,432	11,159,886	11,568,318	12,250,140
Georgia Regional Hospital at Augusta	9,722,438	10,662,821	10,859,288	11,837,134
Northwest Georgia Regional Hospital	9,847,854	10,195,522	9,660,679	10,366,020
Georgia Regional Hospital at Atlanta	10,715,992	11,083,109	12,069,323	12,901,444
Central State Hospital	47,542,620	51,005,613	53,511,793	54,316,984
Georgia Regional Hospital at Savannah	7,949,169	8,467,310	8,975,318	9,719,979
Gracewood State School and Hospital	0	0	0	0
West Central Georgia Regional Hospital	8,141,906	8,275,331	9,108,415	10,032,271
	112,473,995	120,006,661	125,142,504	131,920,891

Regional Offices were established during FY94 with a Director and a Secretary, during FY95 staff were added to assist in monitoring and evaluating the services being provided in the Regions. For FY96 the Regions were given contract authority. The expenditures for FY94 and FY95 were not included in the information given above. There is no clear basis for allocating the expenditures of the Regional Offices between the disabilities.

Institutional Expenditures

		SW	BR	GMHI	Aug	N W	Atl	Cent	Sav	GW	WC	Totals
FY92												
Direct Care	Total	18,994,603	15,251,582	9,922,432	9,722,438	13,316,280	13,108,425	67,636,120	7,949,169	21,059,347	8,141,906	185,102,302
	M R	10,363,019	15,251,582	0	0	3,468,426	2,392,433	20,093,500	0	21,059,347	0	72,628,307
	M H	8,631,584	0	9,922,432	9,722,438	9,847,854	10,715,992	47,542,620	7,949,169	0	8,141,906	112,473,995
FY93												
Direct Care	Total	20,025,786	15,539,725	11,159,886	10,662,821	13,995,171	13,675,793	72,894,856	8,467,310	22,563,977	8,275,331	197,260,656
	M R	10,868,717	15,539,725	0	0	3,799,649	2,592,684	21,889,243	0	22,563,977	0	77,253,995
	M H	9,157,069	0	11,159,886	10,662,821	10,195,522	11,083,109	51,005,613	8,467,310	0	8,275,331	120,006,661
FY94												
Direct Care	Total	20,433,695	16,027,817	11,568,318	10,859,288	13,489,145	14,637,634	75,812,327	8,975,318	23,061,836	9,108,415	203,973,793
	M R	11,044,325	16,027,817	0	0	3,828,466	2,568,311	22,300,534	0	23,061,836	0	78,831,289
	M H	9,389,370	0	11,568,318	10,859,288	9,660,679	12,069,323	53,511,793	8,975,318	0	9,108,415	125,142,504
FY95												
Direct Care	Total	21,973,214	16,239,672	12,250,140	11,837,134	14,329,475	15,147,131	77,415,281	9,719,979	23,917,401	10,032,271	212,861,698
	M R	11,476,295	16,239,672	0	0	3,963,455	2,245,687	23,098,297	0	23,917,401	0	80,940,807
	M H	10,496,919	0	12,250,140	11,837,134	10,366,020	12,901,444	54,316,984	9,719,979	0	10,032,271	131,920,891

Indirect Charges for HAS and DPST were not included in the information for amount spent for the Hospitals.

Community Resources Mental Retardation	M R Comm Asst	M R Day	Foster Grandparents	Proj Rescue	Proj ARC	Grp Home for Autistic Children	Comm M R Staff	Comm M R Residential Services	Clayton Co Bd of Autistic	Totals
FY92	4,783,248	67,010,549	720,719	479,632	372,125	268,956	3,772,707	15,345,918	88,773	92,842,627
FY93	4,869,569	71,712,855	687,670	516,663	379,214	280,746	4,052,005	12,734,629	90,900	95,324,251
FY94	5,156,820	68,702,397	709,623	522,184	382,273	284,276	4,112,266	12,998,866	93,600	92,962,305
FY95	1,895,166	75,153,273	741,236	540,887	444,351	296,263	5,024,171	12,644,003	95,472	96,834,822

Community Resources Mental Health	O T P	M H Comm Asst	Supp Living	CMHCS	Proj Friendship	Totals
FY92	3,139,147	10,393,372	17,560,717	55,683,230	333,482	87,109,948
FY93	3,356,273	11,510,359	20,194,017	52,770,633	340,288	88,171,570
FY94	3,549,819	9,694,014	24,503,632	57,463,510	346,012	95,556,987
FY95	3,660,955	1,885,693	29,651,896	76,470,077	356,684	112,025,305

Expenditures for Division Administration and Substance Abuse Programs were not included with the Community or Hospital information.

Paragraph 21

* Per Diem Rates for Atlanta Regional for applicable years. Dual Diagnosis per diem rate not available.

PER DIEM RATES - GA. REGIONAL HOSPITAL AT ATLANTA

	FY 1992	FY 1993	FY 1994	FY 1995
Adult Psychiatric	207.00	213.00	208.00	219.00
Extended Care	309.00	371.00	268.00	505.00
Forensics (i/p)	211.00	220.00	215.00	221.00
Child and Adolescent	259.00	254.00	226.00	252.00
ICF/MR - #00141061-A	208.00	213.00	206.00	223.00
Alcohol and Drug	406.00	385.00	378.00	335.00

GEORGIA'S
SECTION 1915(b) WAIVER REQUEST TO IMPLEMENT
THE GEORGIA BEHAVIORAL HEALTH PLAN

EXHIBIT 19 (30)

C. COST EFFECTIVENESS

Federal regulations at 42 CFR 431.55 (b) (2) (i) require States to document that waiver programs have and/or will reduce costs or slow the rate of increase of costs and maximize outputs or outcome per unit of cost. With respect to prepaid capitated health plans, 42 CFR 434.23 requires a State to specify its capitation methodology and the actuarial basis for computation of the capitation fees and to document that the capitation fees and other payments do not exceed the upper limits set forth in 42 CFR 447.361.

In fully capitated programs, i.e., those where all waiver services are capitated, calculation of the upper payment limit will constitute a State's projections of costs in the absence of the waiver. In programs where only some services are capitated, or where there are other reimbursement arrangements, additional calculations will be necessary.

Once an upper limit is determined and any other calculations are made which are necessary to compute the costs in the absence of the waiver, then the costs under the waiver must be determined. This is computed by projecting the total capitation fees to be paid along with any other costs such as bonuses, FFS costs for waiver services, or additional administrative costs (if any). The following methodology provides a format for verifying compliance with applicable federal regulations regarding upper payment limits, capitation ratesetting, and cost effectiveness for capitated section 1915(b) waiver programs.

Please refer to Appendix C.2/C.3 for an explanation of the waiver cost estimates.

1. Type of Contract

a. _____ Risk-comprehensive
(fully-capitated -- HMO or HIO or certain PHPs)

b. _____ Other risk (partially-capitated)

c. ✓ Non-risk

SERVICE	WAIVER YEAR 1 - SFY 1997				WAIVER YEAR 2 - SFY 1998			
	undup recip	units /recip	cost/unit	paid amt	undup recip	units /recip	cost/unit	paid amt
Res Training & Sup								
Level I	5	404	$129	$234,192	7	421	$135	$382,069
Level II	90	329	$113	$3,339,945	135	344	$117	$5,448,899
Level III	314	340	$116	$12,368,087	470	354	$121	$20,177,712
Level IV	371	341	$122	$15,392,262	556	355	$127	$25,111,452
Day Habilitation								
hab/daily	475.5	181	$70	$5,998,156	713.3	189	$73	$9,785,593
hab/hourly	286.5	242	$12	$812,669	429.8	252	$12	$1,325,816
supported employment	14	1316	$7	$132,312	28	1373	$7	$287,812
Respite Care								
Level I/Day	4.5	13	$37	$2,142	6.75	13	$39	$3,494
Level II/Day	1.5	8	$37	$454	2.25	9	$39	$741
Level I/Hour	4.5	67	$6	$1,847	6.75	70	$6	$3,014
Level II/Hour	6	68	$6	$2,496	9	70	$6	$4,071
Level III/Day	18	13	$56	$13,652	27	14	$59	$22,272
Level III/Hour	15	68	$9	$9,570	22.5	71	$10	$15,613
Level IV/Day	33	10	$56	$18,895	49.5	11	$59	$30,826
Level IV/Hour	39	57	$9	$20,771	58.5	59	$10	$33,887
Personal Support	270	208	$94	$5,289,197	405	217	$98	$8,628,973
Service Coord. Startup	388	6	$162	$377,902	582	6	$169	$591,227
Service Coord. Cont.	1048	9.82	$154	$1,587,908	1573	9.82	$161	$2,484,281
Environmental Mod	17	1	$4,320	$74,467	25	1	$4,506	$121,488
Vehicle Adaptation	1.5	1	$3,264	$5,114	2.25	1	$3,404	$8,343
Specialized Med Equip	4.5	1	$14,095	$66,264	6.75	1	$14,701	$108,105
PERS								
Installation	3	1	$82	$256	4.5	1	$85	$417
Monthly	12	11	$27	$3,580	18	11	$28	$5,840
Weekly								
Specialized Med Supplies	4.5	12	$74	$3,907	6.75	12	$77	$6,373
MRWP								
Skilled Nursing Visit								
PT	1.5	13	$58	$1,128	2.25	13	$61	$1,840
Speech								
Home health aide	4.5	217	$58	$56,954	6.75	226	$61	$92,917
OT								
UNDUPLICATED RECIPIENTS	1,164				1,746			
TOTAL	3,430	3,936		$45,814,126	5,153	4,104		$74,683,076
PER CAPITA: FACTOR D				$39,359				$42,774

Source: MMIS, 1995. SFY 1995 data have been adjusted for claim lag:	1.12	1.12
Growth in recipients is based on average waiver growth up to the capped limit:	50%	50%
except for supported employment which will double:	100%	100%
Per unit cost growth is based on same as existing 1915(c) waiver:	4.3%	4.3%
Adjusted for ratio of average monthly recipients to unduplicated:	0.88	0.92

08/03/95