DRAFT

FACTUAL ALLEGATIONS from 3 Olmstead Complaints

(seeking Declaratory Judgment, etc.)

DOJ = US Department of Justice

Georgia

DOJ Complaint against the State of Georgia regarding Georgia's Network for Educational and Therapeutic Support Program.

FACTUAL ALLEGATIONS

A. The State's System for Providing Educational Services and Supports to Students with Behavior-Related Disabilities

1. **The Georgia Department of Education ("GaDOE") oversees public education throughout the State, ensuring that laws and regulations pertaining to education are followed and that State and federal money is properly allocated and appropriated.**

2. **The State, through the GaDOE, plans, funds, administers, licenses, manages, and oversees the GNETS Program. It determines which mental health and therapeutic educational services and supports to provide, who will provide such services, in what settings services will be provided, and how to allocate and manage the State and federal funds earmarked for such services.**

3. **The State, through the GaDOE, sets the criteria for students' eligibility for GNETS and establishes the requirements for students' entry into and transition out of GNETS. *See* Ga. Comp. R. & Regs. § 160-4-7-.15(2); Ga. Dept. of Ed., GNETS Operations Manual at 9, 11-12 (Jan. 2014) (the "GNETS Operations Manual"), *available at* http://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/GNETS/FY14 Operations Manual.pdf. The State also has designated an employee to oversee the GNETS Program as well as several employees to oversee implementation of Positive Behavioral Interventions and Supports ("PBIS") across the State.**

4. **Even though mental health and therapeutic educational services and supports can be provided in integrated general education classrooms, the State, including GaDOE, has selected to plan, fund, administer, license, manage, and oversee those services almost exclusively in segregated GNETS centers and classrooms. As a result, local school districts often must send students with behavior-related disabilities to GNETS for such services and supports because the state will not make available the same services in integrated settings.**

5. **The Georgia Department of Community Health ("DCH") is the State agency responsible for Medicaid and PeachCare for Kids®, which is the State's program to implement the federal Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") program that funds Medicaid services for eligible children across the State and the United States. Many mental health and therapeutic educational services and supports, including services and supports provided through the GNETS Program, are reimbursable through the EPSDT program that is administered by DCH.**

6. **The Georgia Department of Behavioral Health and Developmental Disabilities ("DBHDD") is the State agency providing policies, programs, and services for people with mental illness, substance use disorders, and developmental disabilities. DBHDD is responsible for many of the supports and services that are needed by students with disabilities placed in GNETS and delivered through the State-managed care system that DBHDD administers in part. *See* https://dbhdd.georgia.gov.**

7. **During the 2014-2015 school year, the State reported that it served approximately 4,600 students, pre-kindergarten through 12th grade, with behavior-related disabilities in the GNETS Program (the "GNETS Population"). There were approximately 125 pre-kindergarten and kindergarten students in the GNETS Program.**

8. **To be eligible for GNETS services, a student must be a child with an emotional and behavioral disorder "based upon documentation of the severity of the duration, frequency, and intensity of one or more of the characteristics of the disability category of emotional and behavioral disorders ("EBD")," or "[o]ther eligible students with disabilities … [where] the frequency, intensity, and duration of their behaviors is such that [GNETS] placement is deemed by those students' IEP teams to be appropriate to meet the students' needs." *See* GNETS Operations Manual at 1. According to State data, most of the students served in the GNETS Program have a diagnosis of EBD.**

9. **GNETS is divided into 24 regional programs serving all of the State's public school districts. The Program currently serves all of the State's 181 school districts, with some regional programs individually serving over a dozen school districts. *See* GNETS Program Directory FY 16, *available at* https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/GNETS/FY%2016%20GNETS%20Programs.pdf.**

10. **According to State data, in the 2014-2015 school year, students from more than half of all Georgia public schools (1,355 schools) entered the GNETS Program.**

11. **For fiscal year 2016-2017, the State allocated over $72 million in State and federal dollars to the GNETS Program through a line item in the State budget separate from the State's funding of public schools. *See* HB 751 FY 2016-17 Appropriations Bill, § 24.9, *available at* https://opb.georgia.gov/sites/opb.georgia.gov/files/related_files/site_page/FY_2017_Final%20Bill_Governor%20Signed.pdf.**

B. GNETS Centers and GNETS Classrooms Are Segregated, Institutional Settings.

1. **More than two-thirds of all students in the GNETS Program attend school in regional GNETS Centers, which are generally located in self-contained buildings that serve only students with disabilities from multiple school districts. The GNETS Centers severely restrict interactions between students with disabilities and their peers in general education, depriving students in GNETS of the opportunity to benefit from the stimulation and range of interactions that occur in general education schools, including opportunities to learn with, observe, and be influenced by their non-disabled peers.**

2. **Other students in the GNETS Program attend school in regional GNETS Classrooms, which serve only students with disabilities and, although the Classrooms are located within general education school buildings, they are often not the students' zoned general education schools. The GNETS Classrooms may also be located at schools that serve different grade configurations than the grades in which the students in GNETS are enrolled (e.g., a 4th grade student in GNETS may be in a GNETS Classroom in a general education high school).**

3. **Even in GNETS Classrooms that are physically located in general education school buildings, many students placed in the GNETS Classrooms are unnecessarily segregated from their non-disabled peers because the GNETS Classrooms are often located in separate wings or isolated parts of school buildings, some of which are locked and/or fenced off from spaces used for general education programs.**

C. Georgia Administers its GNETS Services in a Manner that has Caused Unnecessary Segregation of Students in State-Run GNETS Centers and GNETS Classrooms and that Places Other Students at Serious Risk of Such Segregation.

1. **Mental health and therapeutic educational services and supports for students with behavior-related disabilities can be provided in integrated educational settings with various levels of services and supports.**
2. **Yet, for over 40 years, the State has operated, administered, and funded the GNETS Program in mostly segregated settings, largely to the exclusion of integrated alternatives.**
3. **The State fails to provide and fund sufficient mental health and therapeutic educational services and supports for children with behavior-related disabilities in integrated educational settings throughout the State.**
4. **The State fails to provide adequate training to general education teachers regarding students with behavior-related disabilities and the supports and services that allow these students to learn in integrated settings. Instead, the State focuses its training and technical assistance resources related to**

serving students with behavior-related disabilities on faculty and staff in segregated GNETS programs. For example, the State provides professional development and training on Functional Behavior Assessments and Behavior Intervention Plans and other evidence-based practices and interventions to GNETS professionals and staff in segregated GNETS programs.

5. **The State uses discriminatory referral, admissions, and exit criteria for the GNETS Program that have the effect of screening out students with disabilities from integrated settings.**

6. **Because the State does not make available adequate or effective integrated mental health and therapeutic educational services and supports for students with disabilities, thousands of students with behavior-related disabilities in Georgia are at serious risk of placement in segregated GNETS programs. For instance, many students are placed at serious risk of placement in the GNETS Program because they are not informed of or given the opportunity to receive integrated mental health and therapeutic educational services and supports prior to receiving a referral or recommendation for placement in GNETS, while other students who are able to transition back to general education classrooms from the GNETS Program are at risk of returning to GNETS because the State fails to provide them with the mental health and therapeutic educational services and supports necessary to allow them to remain in a general education classroom.**

7. **Moreover, the GNETS Program utilizes exit criteria that require students with disabilities to meet behavioral standards that result in students**

unnecessarily remaining in the GNETS Program when they could be served in general education schools.

D. Students with Behavior-Related Disabilities in or at Serious Risk of Placement in the GNETS Program are Qualified to Receive Services in More Integrated Settings and Do Not Oppose It.

1. **The vast majority of students in the GNETS Program could participate in general education schools if the State reasonably modified its delivery of educational services and supports in integrated educational settings. The State unnecessarily segregates students in GNETS from their peers without disabilities and denies them many of the opportunities available in more integrated general education classrooms.**

2. **Mental health and therapeutic educational services and supports are available in Georgia to a limited number of students with disabilities in integrated educational settings. The students who receive such services and supports have disabilities similar to many of the students currently served in the segregated GNETS Program. For many of these students, integrated mental health and therapeutic educational services and supports have enabled them to interact to the fullest extent possible with non-disabled peers and teachers, and, *inter alia*, to participate in curriculum that corresponds to grade level standards, access a range of extracurricular activities, and learn and practice appropriate behaviors in a general education classroom.**

3. **The majority of students in the GNETS Program would not oppose receiving mental health and therapeutic educational services and supports in a more integrated setting.**

E. The State Fails to Offer Students with Behavior-Related Disabilities in the GNETS Program Equal Opportunities to Participate in Electives, Extracurricular Activities, and Other Educational Opportunities.

1. **The State's administration of the GNETS Program results in inequality of educational opportunities for students in GNETS. Students in GNETS generally do not receive grade-level instruction that meets Georgia's State Standards like other students in general education classrooms. Rather, particularly at the high school level, students in the GNETS Centers and Classrooms often receive only computer-based instruction. By contrast, other students in general education classrooms generally receive instruction from teachers certified in the subject matters they are teaching, and in the case of students with disabilities in general education classrooms, also from teachers certified in special education.**

2. **Students in GNETS also often lack access to electives, facilities, and extracurricular activities, such as after-school athletics or clubs, that are available to other students in general education settings. The unequal educational opportunities offered to students in the GNETS Program are specific to and a consequence of students' disability status and concomitant unnecessary segregation.**
3. **Many of the GNETS Centers and Classrooms are inferior facilities in various states of disrepair that lack many of the features and amenities of general education schools, such as gymnasiums, cafeterias, libraries,**

science labs, music rooms, or playgrounds. Some GNETS Centers are located in poor-quality buildings that formerly served as schools for black students during *de jure* segregation.

4. **Approximately one week before the start of the 2016-2017 school year, the GaDOE announced that students currently enrolled in nine GNETS facilities would be transferred to a different location for the start of the school year due to the deteriorating physical conditions and need for structural improvements of those nine facilities.**

5. **Yet, even despite the State's limited plans to move and place some GNETS students into other locations, a lack of equal educational opportunities persists for such students, and will continue to persist, if and when students are moved from one segregated GNETS facility to another. Endemic to all segregated GNETS programs is a lack of access to equal educational opportunities, as—unlike other students in general education settings— students in segregated GNETS settings lack opportunities for grade-level instruction, certified teachers, access to elective and extracurricular activities, and classroom learning complemented by interaction with non-disabled peers. As such, unequal educational opportunities remain a concrete and serious consequence of segregation regardless of the physical integrity of the building that students are placed in.**

F. The State Can Provide Services in Integrated Settings by Reasonably Modifying its Mental Health and Therapeutic Educational Service System for Students with Behavior-Related Disabilities.

1. **GNETS programs are intended to provide a range of mental health and therapeutic educational services and supports, including paraprofessional support, therapeutic interventions, and the services provided by mental health professionals, including psychologists, social workers, psychiatrists, and behavior support specialists.**

2. **Mental health and therapeutic educational services and supports assist students with behavior-related disabilities to identify their behavioral triggers; allow for the development of an individualized plan that relies upon positive support to address those triggers; train teachers, school staff, and parents to properly implement the plan; and allow for coordination with non-school providers of mental health and other services.**

3. **Mental health and therapeutic educational services and supports include comprehensive, strengths-based Functional Behavioral Assessments, Behavioral Intervention Plans, and individualized positive behavioral supports; behavior coaching; case management and individual care coordination; crisis response and stabilization; and social skills training. The federal Medicaid program EPSDT generally authorizes reimbursement to cover such services in a school or community-based setting rather than only in segregated educational institutions.**

4. **While currently provided in segregated GNETS settings, these services, regardless of how they are funded by the State, can be provided in integrated settings, such as general education classrooms, community-based settings near schools, and students' homes. Providing mental health and therapeutic educational services and supports in integrated**

settings would allow students with disabilities in need of those services access to meaningful interactions with non-disabled peers.

5. **Integrated mental health and therapeutic educational services and supports do exist for some students in Georgia, although the State has not funded them, instead electing to fund such services almost exclusively in segregated GNETS settings; such services have allowed those students to be integrated into the general education classroom, socialize regularly with non-disabled peers, and have access to the general education curriculum and teachers. However, for thousands of other students with behavior-related disabilities in or at risk of placement in GNETS Centers and Classrooms across Georgia, these behavior-related services and supports are only available in GNETS Centers and GNETS Classrooms because the State has not made these services and supports available in sufficient supply to meet their needs.**

6. **The State can reasonably modify its programs, policies, and services to remedy these Title II violations and avoid discrimination against students in or at risk of placement in the GNETS Program.**

7. **Reasonable modifications to the State's system for providing mental health and therapeutic educational services and supports can be accomplished by operating a statewide service system that properly evaluates students' individual service needs and whether those needs can be met in integrated general education classes or schools; applying entrance and exit standards for the GNETS Program that are appropriate, clearly identified, equitably applied, and shared with all students and families; and redirecting the State's resources to offer mental health and**

therapeutic educational services and supports for students with behavior-related disabilities in the most integrated setting appropriate for them where they may access equal educational opportunities.

8. **Students in the GNETS Centers and Classrooms could be served by the State in more integrated settings with supports without fundamentally altering the State's service system. Integrated and appropriate educational services and supports for the GNETS Population already exist within the State's educational service system. The State is independently obligated to provide many of these services to Medicaid-eligible children pursuant to the EPSDT requirements of the Medicaid Act. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4), 1396d(r)(1)-(5). If administered appropriately in integrated settings, these educational services and supports would be both cost-effective and capable of meeting the needs of these students with disabilities.**

9. **Integrated mental health and therapeutic educational services and supports are a cost-effective alternative to providing services for students in or at risk of entering segregated GNETS settings. For example, a State audit of the GNETS Program determined that "there is no assurance that GNETS is a cost-effective placement for providing these services." Georgia Department of Audits and Accounts Performance Audit Operations, Georgia Network for Educational and Therapeutic Support (GNETS) at 13 (Oct. 2010), *available at* http://www.gahsc.org/nm/2010/educational%20and%20therapeutic%20support%20-%20gnets%5B1%5D.pdf. The auditors estimated that, in 2009, "the state would have expended a minimum of $42 million to serve these students in local schools rather than GNETS (compared to $58 million in state funds for GNETS)." *Id.* at 22.**

10. **The actions needed to remedy the State's mental health and therapeutic educational service system could be achieved through the redirection, reallocation, expansion, and coordination of existing resources.**

New York

DOJ Complaint against the State of New York regarding "Adult Homes"

FACTS

A. New York's Mental Health Scheme

1. **Pursuant to New York State law, "New York and its local governments have a responsibility for the prevention and early detection of mental illness and for the comprehensively planned care, treatment and rehabilitation of their mentally ill citizens." N.Y. Mental Hyg. Law § 7.01; see also id. §§ 5.07, 7.07. In this regard, "[s]uch a system should include, whenever possible, the provision of necessary treatment to people in their home communities; it should assure the adequacy and appropriateness of residential arrangements for people in need of services; and it should rely upon improved programs of institutional care only when necessary and appropriate." N.Y. Mental Hyg. Law § 7.01.**

2. **Defendant New York State operates its mental health system through two state agencies, the New York State Office of Mental Health ("OMH") and the Department of Health ("DOH"). OMH and DOH administer the State's mental health service system, plan the settings in which mental health services are provided (by both public and private entities) and allocate resources within the mental health service system. See, e.g., N.Y. Mental Hyg. Law §§ 5.07, 7.07, 41.03, 41.42, 41.39; N.Y. Comp. Codes R. & Regs. tit. 18, §§ 485-87.**

3. **Specifically, DOH is responsible for, among other things, promoting the "development of sufficient and appropriate residential care programs for dependent adults." N.Y. Comp. Codes R. & Regs. tit. 18, §§ 485.3(a)(1), 487.1(b). DOH issues operating certificates to establish and operate adult homes. N.Y. Soc. Servs. Law §§ 460-b, 461-b; N.Y. Comp. Codes R. & Regs. tit. 18, §§ 485.3, 485.5. DOH also licenses and monitors adult homes and enforces the applicable statutes and regulations through unannounced inspections of each adult home every twelve or eighteen months, depending on the facility's record. N.Y. Soc. Servs. Law §§ 461-a, 461-b. OMH is also involved in the inspection process. See id. § 485.3(b)(1). OMH is required by law to plan how and where New York's mental health services will be delivered. N.Y. Mental Hyg. Law § 7.07. In particular, OMH is responsible for developing an "effective, integrated, comprehensive system for delivery of all services to the mentally ill and to create financing procedures and mechanisms to support such a system of services to ensure that mentally ill persons in need of services receive appropriate care, treatment and rehabilitation close to their families and communities," and it relies on both public and private providers of those services. Id. § 7.01. OMH also serves an advisory role to "assist the governor in developing policies designed to meet the needs of the mentally ill and to encourage their full participation in society." Id. at § 7.07(b).**

4. **OMH licenses, funds, and oversees an array of mental health housing and support service programs statewide, including community support, residential, and family care programs. N.Y. Mental Hyg. Law §§ 41.03, 41.42, 41.39. Housing programs include Supported Housing, which is a scattered site setting in which individuals live in their own apartment and receive services to support their success as tenants and their integration into the community. In carrying out these roles and responsibilities, the State**

determines what mental health services to provide, who will provide them, in what settings to provide them, and how to allocate funds among various services and settings. By virtue of the manner in which New York has designed, administered, and funded its service system, adult homes are a significant part of the State's mental health service system. Accord DAI, 653 F. Supp. 2d at 192-94; Disability Advocates, Inc. v. Paterson, 598 F. Supp. 2d 289, 317-19 (E.D.N.Y. 2009).

B. Adult Homes Are Not the Most Integrated Setting Appropriate for Persons with Mental Illness

5. **Adult homes are a type of adult care facility licensed by the State of New York and authorized to provide long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator.**

6. **There are approximately 380 adult homes in New York State; approximately 44 of these are in New York City.**

7. **Certain adult homes are known as "impacted" homes. These are adult homes in which at least 25% of the residents, or twenty-five residents, whichever is fewer, have mental illnesses. In Adult Homes, defined herein as impacted facilities with 120 or more total residents in New York City, the proportion of residents with mental illness far exceeds 25%.**

8. **There are approximately 23 Adult Homes in New York City; the vast majority of residents in these homes have mental illness.**

9. **For the most part, Adult Homes have the characteristics of an institution. Accord DAI, 653 F. Supp. 2d at 198-215, 282-88. Residents live with other persons with disabilities, and have limited opportunity to interact with individuals who do not have disabilities. They are assigned to small rooms that they share with at least one other resident. Bathrooms are also shared with at least one other person.**

10. **Residents of Adult Homes have very little autonomy over their daily lives, including over with whom they live and eat meals, and what they eat and when, and are afforded virtually no privacy. Most Adult Home residents are denied the right to administer their own medication, and instead, are required to line up at a medication station at specific times of day. Some Adult Homes require residents to notify staff each time they leave the facility or if they are going to be away from the facility overnight, such as visiting relatives. Some facilities have evening curfews.**

11. **Adult Homes generally control and manage residents' "personal needs allowance" – $187 – from their Social Security Supplemental Security Income (SSI) benefits each month. The remainder of the resident's SSI benefits is paid to the Adult Home.**

12. **Adult Homes do not afford people with mental illness opportunities to achieve greater independence and community integration. For example, the Adult Homes do not permit residents to cook for themselves or do their own**

laundry at the facility. Consequently, the facilities foster learned helplessness. Accord id. at 214-15.

13. **The State itself has characterized residents with mental illness as "stuck" in "institutional settings," including adult homes. OMH Guiding Principles for the Redesign of the OMH Housing and Community Support Policies (2007), at 1; OMH Statewide Comprehensive Plan, 2006-2010 (2008 Update); 2009-2010 Mental Health Update & Executive Budget Testimony of OMH Commissioner M. Hogan (Jan. 29, 2009).**

14. **OMH recently recognized that impacted adult homes are not clinically appropriate settings for the significant number of persons with serious mental illnesses who reside in such settings, and are not conducive to the rehabilitation or recovery of persons with serious mental illness. Clinical Advisory from Lloyd I. Sederer, M.D. to OMH Facility, Clinical, and Nursing Directors, Directors of OMH Licensed Inpatient Programs (August 8, 2012), available at**

www.omh.ny.gov/omhweb/advisories/Clinical_Advisory_Adult.pdf. OMH has further acknowledged that impacted adult homes "do not foster independent living, with the use of congregate meals, ritualized medication administration and programming that may not be tailored to the individual needs of the residents." Office of Mental Health, Notice of Adoption, Operation of Psychiatric Inpatient Units of General Hospitals and Operation of Hospitals for Person with Mental Illness, I.D. No. OMH-32-12-00019-A, NYS Register at 13 (Jan. 16, 2013), available at http://docs.dos.ny.gov/info/register/2013/jan16/pdf/rulemaking.pdf.

15. **Similarly, the Department of Health has recognized that impacted adult homes "do not foster independent living due to institutional practices such as of congregate meals or ritualized medication administration; and do not provide specifically designed rehabilitation programs linked to community work settings." Department of Health, Notice of Adoption, Adult Homes, I.D. No. HLT-32-12-00020-A, NYS Register, at 6 (Jan. 16, 2013), available at http://docs.dos.ny.gov/info/register/2013/jan16/pdf/rulemaking.pdf.**

D. People with Mental Illness in Adult Homes Are Persons with Disabilities Who Are Qualified to Receive Services in More Integrated Settings and Do Not Oppose It

16. **Persons with mental illness residing in, and persons with mental illness at risk of entry into, Adult Homes are individuals with mental illnesses, such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. They are therefore persons with disabilities for purposes of the ADA and the Rehabilitation Act.**

17. **Virtually all of the individuals with mental illness in Adult Homes and those at risk of entry into Adult Homes can be served in more integrated settings, specifically, supported housing. Accord DAI, 653 F. Supp. 2d at 218-23, 229.**

18. **The placement of persons with mental illness in Adult Homes is not based on a determination that such placement is clinically necessary. Instead, people with mental illness tend to end up in Adult Homes following a hospitalization or homelessness because there are no available residential placements in integrated community settings, such as supported housing. Accord id. at 245-46, 260-61.**

19. **OMH currently funds and develops supported housing for individuals with mental illness, including a limited supply of units for adult home residents. Supported housing is an initiative to provide permanent housing, mostly in apartments scattered throughout the community, to individuals with mental illness, with individualized support services to assist them in succeeding in their housing.**

20. **One of the key principles of the State's supported housing program is to separate housing from support services by assisting the resident to remain in the housing of his choice while the services vary to meet the changing needs of the individual.**

21. **Supported housing is a successful, cost-effective program that gives residents the same privacy rights as any other tenant in a landlord-tenant relationship. In supported housing, people with mental illness live much like their nondisabled peers. It is the individual's home. Residents of supported housing sometimes live alone and sometimes share their apartment with a roommate, whom they choose. They can control their own schedules and daily lives. They can come and go when they like, eat what and when they like, decide when to go to sleep and when to wake up, and invite guests over at whatever times they choose. Accord id. at 218-23.**

22. **Compared to residents of Adult Homes, residents of supported housing have far greater opportunities to interact with non-disabled persons and be integrated into the larger community. Accord id. at 218-24, 227.**

23. **People with mental illness in Adult Homes are not materially different from people with mental illness who receive services in more integrated settings, including supported housing. People with mental illness in Adult Homes have similar diagnoses and symptoms of people who live successfully in more independent settings, including supported housing, with the supports and services that exist in the State's community mental health system. Accord id. at 245-47.**

24. **In supported housing, community mental health providers offer a variety of support services, depending on the needs of the individual. Such services include case management such as Assertive Community Treatment ("ACT") or "intensive" or "blended" case management which, among other things, can assist individuals with daily activities such as personal care and safety, grocery shopping and cooking, purchasing and caring for clothing, household chores, using transportation and other community resources, and managing finances.**

25. **Most individuals with mental illness in Adult Homes would not oppose moving to integrated settings such as supported housing, if they had a fully-informed choice and a realistic opportunity to do so. Accord id. at 259-67. Numerous Adult Home residents have expressed their desire to leave the Adult Home and become members of their communities once again.**

E. Serving Individuals with Mental Illness in an Integrated Setting Can Be Reasonably Accommodated

26. Providing services in community settings to individuals with mental illness residing in, or at risk of entry into, Adult Homes can be accomplished with reasonable modifications to the Defendant's programs and services. Accord DAI, 653 F. Supp. 2d at 300-11.

27. The types of programs and services needed to support individuals with mental illness in community-based settings, including supported housing, ACT teams, case management, and peer support services, already exist in New York's mental health service system.

28. However, very few Adult Home residents have accessed the State's community housing programs due to the insufficient supply of supported housing units for the approximately 4,000 residents with mental illness in Adult Homes and the many more individuals with mental illness who are at risk of entry into Adult Homes.

29. Serving individuals with mental illness residing in, or at risk of entry into, Adult Homes in supported housing rather than Adult Homes would not adversely impact the State's ability to serve other individuals with disabilities. Id. at 298-99, 305-08. To the contrary, serving those individuals in supported housing will likely save money, thus freeing State funds to use for other individuals with disabilities. According to DOH, "it is expected that when adult home residents with behavioral health needs transition to appropriate community housing, coupled with appropriate supportive services, their overall utilization of Medicaid-funded services will decrease and significant savings will result." Department of Health, Notice of Adoption, Adult Homes, I.D. No. HLT-32-12-00020-A, NYS Register at 6 (Jan.

16, 2013), available at http://docs.dos.ny.gov/info/register/2013/jan16/pdf/rulemaking.pdf.

F. Resolution of the United States' Claims

30. On November 23, 2009, the court granted the United States' intervention as plaintiff-intervenor in Disability Advocates, Inc. v. Paterson, No. 03-CV-3209 (E.D.N.Y.). The United States participated in implementation of the district court's remedial order and in the State's appeal of the court's order to the Second Circuit. On April 6, 2012, the Second Circuit vacated the district court's remedial order and judgment and dismissed the action for lack of jurisdiction.

31. In lieu of re-filing a complaint, United States officials met with State officials over the past year and exchanged written proposals in an attempt to reach a resolution to the violations identified by the United States in the United States' Complaint in Disability Advocates, Inc. v. Paterson, No. 03-CV-3209 (E.D.N.Y.) and in its on-going investigation. The parties ultimately reached a settlement agreement.

32. Accordingly, all conditions precedent to the filing of this Complaint have occurred or been performed.

Mississippi

DOJ Complaint against the State of Mississippi to enforce the rights of adults with mental illness to receive services in the most integrated setting appropriate to their needs.

FACTUAL ALLEGATIONS

A. State Hospitals are Segregated, Institutional Settings

39. **Mississippi operates four costly, publicly-funded psychiatric hospitals located throughout the State: the Mississippi State Hospital, North Mississippi State Hospital, East Mississippi State**

Hospital, and South Mississippi State Hospital (collectively "the State Hospitals").

40. **The State Hospitals are segregated, institutional settings that do not enable individuals living there to interact with non-disabled persons to the fullest extent possible. While confined in these institutions, individuals are deprived of meaningful opportunities, such as the opportunity to choose friends, participate in employment, or make choices about activities, food, or living arrangements.**

41. **Individuals residing in the State Hospitals live in close quarters with other persons with disabilities. They are assigned to small hospital rooms, often with roommates they did not choose.**

42. **The State Hospitals provide little opportunity for individuals with disabilities to interact with individuals without disabilities, apart from Hospital staff.**

43. **Individuals living in the State Hospitals have very little autonomy over their daily lives. Most aspects of their daily lives are regimented and limited by rigid rules and inflexible practices. These rules and practices include rights restrictions, structured meal times, limits on the ability to have visitors, and limits on travel outside the facilities. As a result, most aspects of their daily lives are controlled by the institutions, and they have little autonomy, privacy, or meaningful opportunities to participate in the community.**

44. **Physically, the State Hospitals are isolated from the general community—they are secluded on large tracts of land and cut off from towns, restaurants, stores, and public transportation, enjoyed by the broader community.**

45. **For instance, the Mississippi State Hospital, established in 1855 and originally known as the Mississippi State Lunatic Asylum, is located on a 350-acre campus in Whitfield, Mississippi, the site of a former state penal colony. The campus consists of over 130 buildings and has its own campus police department.**

46. **The Mississippi State Hospital employs approximately 1,750 employees.**

47. **The East Mississippi State Hospital, located in Meridian, employs approximately 1,130 employees. It was founded in 1882 and was originally known as the East Mississippi State Insane Asylum.**

48. **The North Mississippi State Hospital, located in Tupelo, and South Mississippi State Hospital, located in Purvis, were built recently. The North Mississippi State Hospital opened in 1999 and the South Mississippi State Hospital in 2000. Each of those hospitals employs over 100 full-time staff to cover its 50 beds.**

B. Thousands of Mississippians Cycle in and out of State Hospitals Each Year

49. **Thousands of adults with mental illness in Mississippi needlessly cycle in and out of the State Hospitals each year because they do not receive the supports they need in the community.**

50. **These individuals receive care in a hospital setting away from family, friends, and other natural supports, then return to their communities where they often get no or insufficient treatment, their symptoms get worse, they experience a crisis, and they return to the hospital.**

51. **Not including forensic beds, the State Hospitals have about 500 adult psychiatric beds. Collectively, they serve approximately 3,300 adults per year.**

52. **The average length of stay in the shorter-term units of the State Hospitals is 43 days.**

53. **Many individuals who are admitted to a State Hospital are first held at a local acute psychiatric hospital, crisis stabilization unit, jail, or holding facility while awaiting a placement at a State Hospital, lengthening the overall time spent in an institutional setting.**

54. **Repeat admissions to the shorter-term units of the State Hospitals are common.**

55. **For example, over 55% of the 206 adults in the shorterterm units at the Mississippi State Hospital on a randomly selected day in 2014 had previously been admitted two or more times, and more than 11% had previously been admitted more than *ten* times.**

56. **One twenty-seven year old man admitted to the Mississippi State Hospital on a randomly selected day in March 2015 had *22 prior admissions* to the Hospital. Individuals with persistent needs cycle through the State Hospitals over and over again, to say nothing of**

admissions to local emergency rooms, private psychiatric hospitals, and jails.

57. **Readmissions typically result from insufficient services in the community and inadequate coordination between treating professionals in facilities and those who support the individuals when they are in the community.**

58. **The State often fails to ensure that there is a plan for providing services and supports in the community that will meet the individual's needs and prevent readmission to the State Hospitals. Community mental health centers are core providers supporting people with mental illness when they return to the community, yet they often are not involved in treatment and discharge planning. Other than scheduling a follow-up appointment for the individual at the local provider, there is typically minimal coordination between the State Hospital and the local provider.**

C. Individuals in the Mississippi State Hospital's LongerTerm Units Remain There for Years

59. **Over 100 individuals were institutionalized in the**

Mississippi State Hospital longer-term units in fiscal year 2014.

60. **The average length of stay that year for individuals in the Mississippi State Hospital longer-term units was over seven years. One individual was admitted to the Mississippi State Hospital in 1959, at the age of twenty, and remained there over fifty years, at least until 2015.**

61. **Individuals dually-diagnosed with mental illness and an intellectual or developmental disability may spend years in a State**

Hospital due to the lack of community-based services to meet their needs.

62. **While the State has reduced the number of longer-term beds at the State Hospitals, it has simultaneously transferred many individuals to other long-term, segregated settings, including other Staterun facilities, nursing facilities, and personal care homes. It has also discharged individuals from the State Hospitals to homelessness and other unstable environments.**

63. **Some of the individuals who had been institutionalized at the Mississippi State Hospital have been placed in a nursing facility on the same grounds as a State Hospital.**

64. **Other individuals were discharged to the Central Mississippi Residential Center, a State-funded residential behavioral health program for adults with mental illness that looks much like the State Hospitals. The Center consists of multiple buildings on an isolated campus in Newton, Mississippi with a capacity to serve 68 individuals at a given time. The average length of stay at the Center is 545 days; however, several individuals have lived at the Center for five years or more, many of whom already spent much of their lives in a State Hospital.**

65. **Mississippi's State Hospitals fail to offer appropriate treatment and discharge planning necessary to successfully transition individuals to the community. Discharge plans are frequently boilerplate and disconnected from the skills individuals need in order to live in the community.**

D. Mississippi's Administration of its Service System has Caused Unnecessary Segregation of Individuals in State Hospitals and Placed Others at Serious Risk of Unnecessary Institutionalization

66. **Through the Mississippi Division of Medicaid and Department of Mental Health, the State determines what services will be provided, where services will be available, how services will be funded, who will be eligible for services, how service quality will be evaluated, and what providers are permitted to offer the services.**

67. **The Mississippi Department of Mental Health funds and operates the State Hospitals.**

68. **The Mississippi Department of Mental Health and Division of Medicaid plan, contract, fund, regulate, and oversee the community mental health system that provides community-based alternatives to the State Hospitals.**

69. **The State offers community-based mental health services primarily through fourteen regional community mental health centers ("CMHCs"). The CMHCs are the principal service providers with whom the Mississippi Department of Mental Health and Division of Medicaid contract to furnish a range of community-based mental health and substance abuse services to persons with disabilities, including mental illness. The Mississippi Department of Mental Health is responsible for certifying, monitoring, and assisting the CMHCs.**

70. **The CMHCs are required to offer certain mental health services, including psychiatric services, individual and group therapy, community-based support services, crisis services, and peer support services. Some CMHCs also offer more intensive services, like Assertive Community Treatment, supported employment, and residential services. In addition, the Department of Mental Health pays the CMHCs to conduct pre-screening evaluations to determine whether individuals are eligible for admission to a State Hospital.**

71. **The Mississippi Department of Mental Health and Division of Medicaid exercise control over the availability and quality of community mental health services in the State.**

72. **The Mississippi Department of Mental Health certifies each CMHC prior to its selection as the designated provider, promulgates operational standards for all CMHCs, conducts reviews of CMHC operations, awards**

grant funds to support specific community services, and requires financial and performance reporting.

73. **The Mississippi Division of Medicaid establishes the Medicaid services that will be available, defines the purpose of those services, defines limits on those services, engages in utilization control, and determines the rates for those services.**

74. **Numerous policies, practices, and actions by the State, including the Mississippi Department of Mental Health and Division of Medicaid, have led to the unnecessary segregation of individuals with mental illness in State Hospitals and placed many other individuals with mental illness at serious risk of institutionalization. Despite being aware that it unnecessarily relies on an institutional model to serve individuals with mental illness, the State continues to discriminate against people with mental illness by failing to provide sufficient, integrated community-based mental health services consistent with their individual needs. It has done so primarily by: (1) failing to provide sufficient community-based mental health services throughout the State and (2) concentrating funding in its State Hospitals rather than community-based services.**

i. **The State fails to provide sufficient community-based mental health services throughout the State.**

75. **The State recognizes that community-based services, including psychiatric services, individual and group therapy, intensive case management, crisis services, peer support services, Assertive Community Treatment, supported employment, and permanent supported housing promote positive outcomes and prevent hospitalizations among persons with serious mental illness. See, e.g., Mississippi Department of Mental Health, Think Recovery Newsletter 1, 6-7 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/09/MS-RecoveryNewsletter-Summer-2015.pdf (last visited January 13, 2016).**

Individuals with mental illness living in the community may need one or more of these community-based services at any given time to avoid unnecessary hospitalization. Yet the State fails to sufficiently provide communitybased mental health services, particularly in certain geographic areas of the State, leaving thousands of people who are in the State Hospitals or at serious risk of entering those Hospitals without the ability to access needed community-based treatment.

76. **In fiscal year 2015, nearly 5,500 individuals were screened for non-forensic admission and about 3,300 were ultimately placed in a State Hospital. More individuals could be diverted from costly, segregated institutional placement at the State Hospitals if the State increased the availability of community-based services.**

77. **Crisis services are a critical part of a successful community mental health system because effective crisis professionals can divert individuals from institutionalization and link them quickly to needed community-based services. For instance, mental health clinicians offering mobile crisis services go into the community to meet individuals at the site of a crisis and offer interventions to prevent hospitalization. Crisis professionals can also work closely with law enforcement to help divert individuals from arrest and incarceration or civil commitment.**

78. **The State acknowledges that "[w]ithout mobile crisis intervention, someone experiencing a mental health crisis may end up in a hospital, inpatient psychiatric program, a holding facility or even a jail." Mississippi Department of Mental Health, Mississippi Profile 9 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/03/Mississippi-Profile-Winter-and-Spring-2015.pdf (last visited January 13, 2016).**

79. **The State, however, is not ensuring that these critical faceto-face interventions are uniformly available to individuals in crisis across the State. While one CMHC reported over 3,000 face-to-face mobile crisis interventions in fiscal year 2015, another CMHC, with a nearly identical regional population, reported fewer than 50 face-to-face interventions all year.**

80. **Assertive Community Treatment ("ACT") is another critical community-based mental health service that is not sufficiently available in Mississippi. It is an intensive team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness to increase integration and prevent hospitalizations. Substance Abuse and Mental Health Services Administration, Assertive Community Treatment: Building Your Program 5, Pub. No. SMA08-4344 (2008).**

81. **The State recognizes the importance of ACT in helping individuals with serious mental illness remain stable in the community and avoid unnecessary institutionalization. A Mississippi Department of Mental Health press release about the State's ACT program stated, "[i]n the four years DMH has had [ACT] teams operating, they have been extraordinarily successful in helping individuals in recovery by ensuring they can stay and participate in the communities of their choice." Further elaborating on the success of the program, the Department of Mental Health Executive Director, Diana Mikula, stated, "Recovery not only benefits the individual, it benefits the entire community. . . . Evidencebased programs such as [ACT] Teams are essential to keep individuals in the community and help them continue on their road to recovery." Mississippi Department of Mental Health, Mississippi Expands Program of Assertive Community Treatment Teams, *available at* http://www.dmh.ms.gov/mississippi-expands-program-of-assertivecommunity-treatment-teams/ (last visited January 13, 2016).**

82. **In spite of this recognition, the State only offers ACT services in about half of its fourteen community mental health regions statewide, and the existing teams serve a very small number of individuals.**

83. **In fiscal year 2015, the State served only 189 people with ACT through its eight ACT teams, despite the overwhelming need for the service.**

84. **ACT teams are designed to serve between 80 and 100 individuals each, so the existing teams could serve between 640 and 800 individuals while implementing the service with fidelity to the evidencebased model. Due to poor implementation of the service, the teams remain underutilized.**

85. **The absence of ACT capacity is particularly palpable in the Jackson area. Hinds and Rankin counties, covering the Jackson metropolitan area, send more people to State Hospitals for treatment than any other counties in Mississippi; in fiscal year 2015, 307 people from Hinds County and 206 people from Rankin County were served in the State Hospitals. Together, the two counties account for about 17% of the people served in the State Hospitals, yet neither county had an ACT team until 2015.**

86. **An ACT team was established in Hinds County in 2015,**

but because it only served 17 individuals, it had little impact on reducing the number of State Hospital admissions. No ACT team serves Rankin County.

87. **The State has begun to establish a certified peer support program through which individuals who have lived with mental illness assist others with mental illness to increase resiliency, manage symptoms, build community living skills, and work toward recovery in order to live integrated lives in the community and avoid hospitalization. The State recognizes that peer support can be just as valuable as other professional treatment services for people with mental illness. See Mississippi**

Department of Mental Health, Think Recovery Newsletter 1 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/09/MS-Recovery-Newsletter-Summer-2015.pdf (last visited January 14, 2016).

88. **Peer support services are not sufficiently available throughout the State, however. In fact, two of the CMHC regions each employ only a single peer support specialist. Over 450,000 people live in the 14 counties served by those CMHCs.**

89. **Permanent supported housing is another service that enables people with serious mental illness to avoid hospitalization. As its name implies, permanent supported housing is (1) permanent, meaning "tenants may live in their homes as long as they meet the basic obligations of tenancy[;]" (2) supportive, meaning "tenants have access to the support services that they need and want to retain housing;" and (3) housing, meaning "tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities." Substance Abuse and Mental Health Services Administration, Permanent Supportive Housing: Building Your Program 1, Pub. No. SMA-10-4509 (2010).**

90. **The State has recognized the need for permanent supported housing as an effective evidence-based service for individuals with serious mental illness that enables people to live integrated lives in the community and avoid institutionalization. See Technical Assistance Collaborative, A Statewide Approach for Integrated Supportive Housing in Mississippi 1-3 (2014); House Bill No. 1563 (2015).**

91. **The State acknowledges, however, that sufficient permanent supported housing is not available in Mississippi to meet the needs of persons with mental illness. The State calculates that over 7,000 people are candidates for permanent supported housing, and that it would need to provide at least 2,900 slots to meet the national rate of permanent**

supported housing availability. Still, the State has provided funding for what they estimate will support only 200 permanent supported housing slots for fiscal years 2015 and 2016. See House Bill No. 1563 (2015).

92. **The insufficiency of community services coupled with inadequate State Hospital discharge planning places people at serious risk of readmission to a State Hospital. Individuals are frequently discharged from a State Hospital without sufficient community supports in place and to inappropriate housing, such as homeless shelters. For instance, in fiscal year 2014, at least 56 individuals were discharged to homelessness.**

93. **Mississippi's failure to develop a sufficient, high-quality supply of community-based services and failure to conduct adequate discharge planning from its State Hospitals to the community forces individuals with mental illness to obtain necessary services at inappropriate and costly venues, such as emergency rooms, jails, and psychiatric hospitals.**

ii. **The State fails to fund sufficient community-based services and instead focuses funding on institutional settings.**

94. **The State's reliance on institutional care is reflected in its spending.**

95. **In spite of a challenging fiscal environment, the State has continued to concentrate funding on costly institutional care at State facilities when it could provide appropriate, less expensive services in the community and share the cost of many of those services with the federal government.**

96. **Virtually all of the costs of the State facilities are paid for with State general funds. When the State provides community alternatives through its Medicaid program, however, the federal government provides matching funds; the federal government pays for 73% of all Medicaid expenditures in Mississippi. Federal Medicaid dollars are not available to fund inpatient psychiatric services for adults under 65 in the State**

Hospitals, but would be available to all Medicaid beneficiaries receiving eligible community-based services.

97. **In fiscal year 2015, the Mississippi Department of Mental Health spent $202.5 million on the State Hospitals. In addition to the State Hospitals, the State has concentrated resources in its 68-bed Central Mississippi Residential Center. In fiscal year 2015, the State spent $5.8 million to operate the Center.**

98. **The State reports that the cost for one individual in the State Hospitals is over $470 per day, on average. Based on the CMHC Billing Guidelines, the approximate cost to the State (minus the federal portion) to serve Medicaid eligible individuals with the most intensive needs who instead receive ACT in the community is approximately $30 per day. And many individuals served at the State Hospitals will not need the most intensive and most expensive community-based services in order to avoid unnecessary hospitalizations.**

99. **The Mississippi Legislature's Joint Committee on Performance Evaluation and Expenditure Review committee reported in 2008 that, generally, institution-based services cost more per client than community-based services and that the State's focus on institution-based care "represents a much more expensive service delivery model than does community-based care." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis 55 (2008).**

100. **The State's recent spending on new facilities at the East Mississippi State Hospital is another example of its significant investment in the State Hospitals. In the last two years, the State has funded several new buildings at East Mississippi State Hospital, with the newest ones**

currently under construction. In 2014, the State opened a new $7 million dining facility. The State is currently spending $14 million to build a brand-new 60-bed unit and a central mechanical building.

101. **Even though the State modified its Medicaid State Plan in 2012 to make some critical community-based mental health services Medicaid reimbursable, including mobile crisis, ACT, and peer support, these services are still not being offered in sufficient quantity. For instance, in fiscal year 2014, Medicaid only reimbursed providers for serving 60 people with ACT and 533 people with peer support. Yet offering these Medicaid reimbursable services makes economic sense given the federal government's matching funds.**

102. **Mississippi could serve individuals with mental illness in the community by maximizing existing resources—both by redirecting spending from segregated, institutional settings to community-based programs and by fully implementing the State's Medicaid State Plan services.**

E. Mississippi is Aware That it Unnecessarily Relies on Institutional Settings and has not Taken the Action Needed to Remedy the Violations of Law

103. **The State has long been aware of the failures of its mental health system. In recent years, Mississippi has recognized, and reported on, the State's significant reliance on institutional care to serve persons with disabilities, including mental illness.**

104. **In 2008, the Mississippi Legislature's PEER Committee issued a comprehensive report that concluded that the Board of Mental Health had not focused on developing adequate community-based programs and reallocating resources to meet the emergent needs of persons with mental illness in Mississippi. Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 511, Planning for the**

Delivery of Mental Health Services in Mississippi: A Policy Analysis 5456 (2008). The PEER committee concluded that Mississippi was out-ofstep with national trends and was failing to meet the needs of persons with disabilities in integrated community settings. Id. at 1 ("Although the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods.").

105. **The PEER committee recognized that, due to the ADA and the Olmstead decision, "the state will be forced to move toward providing more community-based care in the near future." Id. The PEER committee concluded that the State was not in a good position to address outstanding issues because the Mississippi Board of Mental Health "has not aggressively sought plans for reallocation of resources to meet emerging needs in addition to efforts to seek additional funding to meet those needs . . . [thus,] allowing the development of community-oriented programs to fall behind." Id.**

106. **In June 2014, the PEER committee again found that the State has missed opportunities to provide community-based services. In a report related to the closure of the Mississippi State Hospital's Community Services Division, the PEER committee noted that the Department of Mental Health redirected resources from the closure of community-based programs into the State Hospitals, thus "forgo[ing] the opportunity to redirect the resources yielded from closure of the [community services] division into providing community-based mental health care." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 584, A Review of the Closure of the Mississippi State Hospital's Community Services Division viii (2014).**

107. **In a May 2015 report, the PEER committee again reiterated that "Mississippi will be forced to move toward providing more community-**

based mental health care in the near future" and recommended that "[t]he Department of Mental Health and Mississippi State Hospital should gather the appropriate data sets regarding the mental health needs of the hospital, the communities, and the state in order for the department to articulate its community-based services strategy, design its implementation process, and reallocate its resources." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 593, Staffing of Psychologists at the Mississippi State Hospital in a Changing Mental Health Service Delivery Environment 1 (2015).

108. **As early as 2001, the State acknowledged the need for significant change in its Olmstead Plan. The Olmstead Plan, developed in conjunction with various stakeholders, was entitled Mississippi Access to Care ("MAC"), and was submitted to the Mississippi Legislature on September 30, 2001. Mississippi Access to Care Plan (2001), *available at* https://www.medicaid.ms.gov/wp-content/uploads/2013/12/MAC_2001Plan.pdf (last visited January 14, 2016). The overall stated purpose of the Plan was to "create an individualized service and support system that enables individuals with disabilities to live and work in the most integrated setting of their choice. It is our vision that all Mississippians with disabilities will have the services and supports necessary to live in the most appropriate and integrated setting possible." Id. at 9.**

109. **Among the many changes that the Plan identified as necessary to realize this vision were the development of community housing alternatives for over 1,000 adults with serious mental illness, the expansion of the State's supported employment program, and the expansion of intensive case management. Id. at 22, 28, 39.**

110. **The first and only implementation report explained that while some agencies were attempting to implement the reforms identified in the**

State's Olmstead Plan, the State had not funded the Plan and this made full implementation impossible. MAC Implementation Report #1 5 (2003).

111. **After ten years in which the State did not engage in any meaningful Olmstead planning, the State launched MAC 2.0 in 2013. MAC 2.0 is apparently an umbrella for workgroups related to specific federal grant programs.**

112. **This MAC 2.0 initiative has not resulted in a revised Olmstead Plan. See Mississippi Division of Medicaid, Mississippi Access to Care (MAC) 2.0, *available at***

https://www.medicaid.ms.gov/mississippi-access-to-care-mac-2-0/ (last visited January 14, 2016).

113. **The Department of Mental Health's current strategic plan also recognizes that expansion of community-based services and supports is critical. The strategic plan is aimed at "moving toward a communitybased service system." Mississippi Board of Mental Health, FY16-FY18 DMH Strategic Plan 1.**

114. **The goals in the current plan highlight the continued need for reform. The plan calls for providing supports in the community "to prevent out-of-home placements[;]" ensuring access to crisis services to "divert individuals from more restrictive environments such as jail, hospitalizations, etc.[;]" providing adults with serious mental illness access to "appropriate and affordable housing[;]" and using peer support to "assist individuals in regaining control of their lives and their own recovery process[.]" Id. at 8.**

115. **Nearly fifteen years after developing the State's Olmstead Plan, the State still is not meeting its obligations under the ADA to serve adults with serious mental illness in the most integrated setting appropriate.**

F. Individuals with Mental Illness in State Hospitals Or at Serious Risk of Hospitalization are Persons with Disabilities Who are Qualified to Receive Services in More Integrated Settings and Do Not Oppose It

116. **Individuals admitted to or at serious risk of entry into State Hospitals have mental illnesses, such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. They are therefore persons with disabilities for purposes of the ADA.**

117. **A vast majority of the individuals with mental illness in the State Hospitals and those at serious risk of entry into those hospitals are qualified to receive mental health services in the community and can be served in more integrated settings.**

118. **People in the State Hospitals and those at serious risk of entry into those hospitals are similar to people with mental illness who receive services in the community. They have similar diagnoses and needs as people who live successfully in more independent communitybased settings with the types of supports and services that currently exist in the State's community mental health system.**

119. **Persons with mental illness at the State Hospitals would not oppose moving to and receiving services in integrated settings if appropriate community-based services were available and if individuals had a realistic opportunity to do so.**

120. **Individuals in the State Hospitals routinely request to leave the facility and return to their own communities.**

G. The State Can Provide Services in Integrated Settings by Reasonably Modifying Its Mental Health Services System

121. **The State can provide services in integrated community settings to people with mental illness who are currently held in State Hospitals and to people with mental illness at serious risk of entry into State Hospitals through reasonable modifications to its mental health services system.**

122. **The types of services needed to support people with mental illness in community-based settings already exist in Mississippi's community-based mental health service system.**

123. **However, these services are not sufficiently provided to meet the needs of persons who are unnecessarily institutionalized or those at serious risk of institutionalization.**

124. **With reasonable modifications, including expansion of the capacity to provide existing services, reallocation of funds from institutions, and maximization of the State's Medicaid program, Mississippi's community mental health system would be able to meet the needs of people with mental illness in State Hospitals or at serious risk of being placed in a State Hospital.**

H. The United States' Investigation

125. **After receiving an allegation of discrimination, in 2011, the**

United States investigated the State of Mississippi's compliance with Title II of the ADA. On December 22, 2011, the United States issued its findings and conclusions in a letter to the Governor, concluding that the State fails to provide services to adults with mental illness in the most integrated setting appropriate to their needs as required by the ADA and

Olmstead. Letter from United States Department of Justice, Civil Rights

Division to The Honorable Haley R. Barbour (Dec. 22, 2011).[1] The letter reported in detail the findings of the United States' investigation, provided the

State notice of its failure to comply with the ADA, and outlined the steps necessary for the State to meet its obligations pursuant to federal law.

126. **Nonetheless, the State continues to fail to ensure that adults with mental illness are served in the most integrated setting appropriate to their needs, or that their discharge planning needs are met in order to transition successfully into community settings.**

127. **The United States engaged in multiple rounds of negotiations with the State beginning in the spring of 2012. The United States has determined that compliance cannot be secured by voluntary means. Judicial action is, therefore, necessary to remedy the violations of law identified in the United States' letter and to vindicate the rights of the adults with mental illness in or at serious risk of institutionalization in State Hospitals.**