UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

T.R., by and through his guardian and next friend, R.R.; S.P., by and through her mother and next friend, DH; C.A., by and through her mother and next friend, A.A.; T.F., by and through her father and next friend, D.F.; P.S., by and through his mother and next friend, W.S.; T.V., by and through his guardian and next friend, C.D.; G.B., by and through her mother and next friend, L.B.; E.H. by and through his mother and next friend, C.H.; E.D., by and through his mother and next friend, A.D.; and L.F.S., by and through his mother and next friend, B.S. Plaintiffs, v. SUSAN N. DREYFUS, not individually, but solely in her official capacity as Secretary of the Washington State Department of Social and Health Services; Defendant.	No. **CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF**

The named Plaintiffs herein, by and through their counsel, and on behalf of themselves and the class they represent, allege as follows:

I. BRIEF STATEMENT OF THE CASE

1. This Complaint asserts a class action lawsuit to enforce the rights of Washington's Medicaid eligible children under the age of 21, with mental health needs, to

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receive the intensive home and community-based mental health services necessary to correct or ameliorate their mental health conditions.

2. Since at least the year 2002, Washington's Department of Social and Health Services ("DSHS") has commissioned and issued numerous studies and reports that confirm the inadequacy of the State's current system of mental health care for Washington's Medicaid children and that recommend the wide-spread adoption of intensive home and community-based mental health services ("Intensive HC-based Services"). Yet, to date, Washington's Medicaid children have little or no access to such services.

3. The State's failure to ensure that Washington's Medicaid eligible children are provided necessary, Intensive HC-based Services violates: (1) the Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") provisions of Title XIX of the federal Social Security Act ("Medicaid Act"); and (2) the Integration Mandate of the Americans with Disabilities Act (the "ADA") and Rehabilitation Act.

4. Within Washington's Medicaid system, many children with significant mental health needs can only access a limited tool kit of weekly office-based therapy and medication management. If those limited services are insufficient, the only option generally available for these children is hospitalization in an acute care psychiatric hospital or placement in a long term institutional mental health facility.

5. The named Plaintiffs in this action are ten children between the ages of nine and 17 who suffer from various psychiatric and behavioral disorders. They and the Plaintiff class cannot access critical Intensive HC-based Services due to Defendant's failure to provide them with information and notice of their right to access such services, failure to administer adequate screening and assessments to address the children's community mental health needs, and failure

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to manage the State's Medicaid mental health system so as to ensure that these children actually have access to and are provided the Intensive HC-based Services necessary to correct ameliorate their mental health conditions.

6. As a result of the Defendant's failure to arrange and provide for necessary Intensive HC-based Services, the named Plaintiffs and thousands of other similarly situated children have suffered: a) family separation and instability, including homelessness, eviction, foster care placement, and out-of-state placement; b) repeated and avoidable hospitalizations; c) unnecessary and harmful juvenile detention; d) segregation through unnecessary, prolonged and often harmful institutionalization; and e) worsening mental and physical health conditions contributing to their decline socially, academically and in daily living.

7. Plaintiffs and the class of children they represent, are cycling in and out of hospitals, juvenile detention centers, long-term psychiatric institutions, and foster care placements that may be hundreds of miles away from their homes and families. Children should grow up at home, not in institutions, and the revolving door of institutionalization and lack of services must end.

8. Three of the named Plaintiffs are currently institutionalized; five have recently been discharged after almost a year or more of institutionalization and are currently being deprived of necessary post discharge services that would allow them to remain safely at home. Each of these children has experienced multiple hospitalizations or institutionalization. The remaining two named Plaintiffs have avoided hospitalization or institutionalization but have been denied the Intensive HC-based Services they need to address their significant mental health symptoms of self harming behaviors and threatened suicide. If these children do not receive

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immediate treatment they are at high risk of institutionalization and will join the other named Plaintiffs in the cycle of institutionalization and denial of services.

9. This failure to provide intensive HC-based Services has decreased the chance that each of these children, and the class they represent, will become independent and productive adults.

10. The named Plaintiffs seek declaratory and injunctive relief to enforce the Medicaid Act, the Americans with Disabilities Act, the Rehabilitation Act and the Fourteenth Amendment to the United State's Constitution so that Intensive HC-based Services will be available to them and others similarly situated.

II. JURISDICTION AND VENUE

11. This class action for declaratory and injunctive relief arises under 42 U.S.C. §§ 1983 and 1988, the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq. ("ADA") and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Defendant is a state actor whose actions giving rise to this suit were under color of state law.

12. Jurisdiction is proper in this Court pursuant to 28 U.S.C. § 1331 and 1343(a). Plaintiffs' claims for declaratory and injunctive relief are authorized under 28 U.S.C. § 2201 and 2202 and Rules 57 and 65 of the Federal Rules of Civil Procedure.

13. Venue is appropriate in the Western District of Washington pursuant to 28 U.S.C. § 1391(b) because Defendant is sued in her official capacity and performs her official duties by and through offices within the District and thus resides therein, and a substantial part of the events and omissions giving rise to the claims herein occurred in this District. Many of the named Plaintiffs also reside in this District.

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III. INTRODUCTORY STATEMENT

14. Historically, children with intensive mental health care needs were either treated in large institutional asylums or were left untreated and faced a future of juvenile detention and adult incarceration, homelessness or ever declining psychological, physical and social conditions. There is now widespread agreement among children's mental health experts that these restrictive, institutional treatment centers pose additional risks and can be a harmful environment for children. By contrast, years of research and clinical experience have proven that intensive home and community-based mental health services are both successful and cost effective. Such services are now relied upon as a necessary treatment modality even for children with the most severe emotional and behavioral problems. As a result, courts around the country have required that state Medicaid programs ensure the provision of Intensive HC-based Services under Medicaid's EPSDT requirements. And, recognizing their legal obligation and the effectiveness of such services, several states have voluntarily reformed their systems to ensure that such services are made available to their Medicaid children and youth.

15. DSHS has repeatedly received recommendations for, and has itself recognized the need for, wide-spread adoption and expansion of Intensive HC-based Services but has failed to implement the necessary systemic changes to provide for the delivery of these services statewide. While pilot programs exist, they are available only to a fraction of the population and are often funded by non-Medicaid funds. Other services may become available only if the child's parent relinquishes custody to the foster care system, tearing the child away from a caring and loving family environment and introducing further instability. And, while a few community mental health providers offer limited home and community-based services to Medicaid children, these

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services are frequently inadequate and offered only to a privileged few or in restrictive circumstances.

16. By failing to create and support intensive services in children's homes and communities, and only offering intensive services in restrictive institutional settings, the system is placing Plaintiffs and the members of the Plaintiff class at risk of (and in many cases ensuring) avoidable psychiatric hospitalizations or commitment to the juvenile delinquency system.

17. The cost to taxpayers of failing to provide necessary treatment and services to children is well documented: inadequate care leads to a worsening of symptoms, with costlier consequences requiring more expensive responses. The cost in lost opportunities to the children themselves— through higher school drop out rates, involvement in the juvenile and criminal justice systems, and a very real prospect of a lifetime of cycling in and out of state psychiatric hospitals —cannot be calculated.

18. The harm to the named Plaintiffs and to the Plaintiff class is irreparable. While the Defendant delays systemic reform, the childhood of each of the named Plaintiffs and Plaintiff class members is literally slipping away as they spend days, weeks, months, and years in institutions, detention centers, and out of home placements far from their families and communities. Injunctive and declaratory relief are necessary and appropriate because absent relief ensuring that Plaintiffs are provided necessary and legally required services, the named Plaintiffs and the class they represent will continue to suffer as a result of Defendant's continued violations of their legal rights.

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IV. PARTIES

The Plaintiff Children

19. **T.R.** is a ten-year-old boy from King County with significant mental health care needs. Although his treatment team recognizes that his condition will only worsen in an institutional environment, he is unable to access the intensive home and community-based mental health services that would allow him to safely return home. Instead he has remained confined for the last nine months at the state psychiatric hospital for children on the grounds of Western State Hospital. T.R. brings this action through his sister, legal guardian and next friend, R.R. T.R. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in King County, Washington.

20. **S.P.** is a 16-year-old girl from Spokane County, Washington with significant mental health care needs. S.P. was recently discharged from an inpatient psychiatric facility and, like the five times she had been previously discharged, was denied the Intensive HC-based Services that she requires to remain safely at home. As a result, shortly thereafter she was recommitted and is currently institutionalized. S.P. brings this action by and through her mother and next friend, D.H. S.P. is a Medicaid recipient for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in Spokane County, Washington.

21. **C.A.** is a 15-year-old girl from Island County, Washington with significant mental health care needs. By the time she was 14, C.A. had been hospitalized three times due to depression and a suicide attempt, and she had begun cutting herself. Although she can be treated at home with Intensive HC-based Services, she is currently institutionalized. C.A. brings this action by and through her mother and next friend, A.A. C.A. is a Medicaid recipient for whom

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Defendant has failed to arrange and provide for necessary Intensive HC-based Services in Island County, Washington.

22. **T.F.** is a 15-year-old girl from Spokane County, Washington with significant mental health care needs. In order to receive Intensive HC-based Services, T.F. is currently placed in a foster home in Kennewick, Washington, over 150 miles away from her home and family. Due to the lack of available Intensive HC-based Services, she has been in out-of-home placements and institutions since she was ten years old. T.F. brings this action by and through her father and next friend, D.F. T.F. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in Spokane County, Washington.

23. **P.S.** is a 17-year-old boy from King County, Washington with significant mental health care needs. Because P.S. has been repeatedly denied necessary Intensive HC-based Services, he has spent his childhood bouncing between institutions, hospitals, and juvenile detention. P.S. brings this action through his mother and next friend, W.S. P.S. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services in King County, Spokane County, and Yakima County, Washington.

24. **T.V.** is an eleven-year-old boy from Spokane County, Washington with significant mental health care needs. After a year at the state psychiatric hospital for children, T.V. was recently discharged and is currently being denied the step-down Intensive HC-based Services he needs to prevent relapse. T.V. brings this action by and through his legal guardian, C.D. T.V. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in Spokane County, Washington.

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25. **G.B.** is a 13-year-old girl from King County, Washington with significant mental health care needs. After spending almost two years in the state psychiatric hospital, G.B. was recently discharged to her family with in-home mental health services to address her aggression and self harm. These Intensive HC-based Services were abruptly terminated by her Medicaid provider based solely on arbitrary limits unrelated to her needs, thereby placing G.B. at significant risk of re-institutionalization. G.B. brings this action by and through her mother, L.B. G.B. is a Medicaid recipient and has requested, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in King County, Washington.

26. **E.H.** is a 15- year-old boy from Whitman County, Washington with mental health care needs. In spite of frequent incidents of self-harm, attempted suicide, and threats to others, E.H. was recently discharged from an institution and has yet again been denied the Intensive HC-based Services that would stabilize him in his home. E.H. brings this action by and through his mother and next friend, C.H. E.H. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services, in Whitman County, Washington.

27. **E.D.** is a ten-year-old boy King County, Washington with significant mental health care needs from. E.D. has never been institutionalized, but he has serious and dangerous unmet mental health needs that are placing him at risk of falling into the vicious cycle of hospitalizations that his fellow named Plaintiffs have suffered. E.D. brings this action by and through his mother and next friend, A.D. E.D. is a Medicaid recipient for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services in King County, Washington.

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28. **L.F.S.** is a nine-year-old boy from Spokane County, Washington with mental health care needs. L.F.S. has been exhibiting severe mental health symptoms for the last five years, but has yet to receive an adequate assessment of his condition or Intensive HC-based Services. L.F.S brings this action by and through his mother and next friend, B.S. L.F.S. is a Medicaid recipient, for whom Defendant has failed to arrange and provide for necessary Intensive HC-based Services in Spokane County, Washington

The Defendant

29. Susan N. Dreyfus is Secretary of the Washington State Department of Social and Health Services. Secretary Dreyfus is named solely in her official capacity as DSHS Secretary for declaratory and prospective injunctive relief. DSHS administers Washington's Medicaid program. Secretary Dreyfus is the designated State Mental Health Authority under Washington's Community Mental Health Services Act, RCW 71.24. RCW 71.24.035. Secretary Dreyfus's duties include assuring access to mental health treatment services for children, RCW 71.24.035.

30. Secretary Dreyfus is responsible for ensuring that Washington's Medicaid and mental health services are administered in a manner consistent with state and federal law.

V. THE CLASS ACTION ALLEGATIONS

31. This action is brought as a statewide class action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2). The proposed class consists of all current or future Medicaid-eligible residents of Washington under the age of 21 who have or may in the future have a mental illness or condition and who need, or may in the future need, but are not receiving, intensive home and community-based mental health services in order to correct or ameliorate their mental illness or condition.

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32. The class is so numerous that joinder of all members is impracticable. By way of example, DSHS data shows that there are more than 75,000 children between the ages of zero and 17 who are low-income with a mental health diagnosis in the moderate to severe range and thus would likely benefit from Intensive HC-based Services that are routinely unavailable statewide. Plaintiff class, which includes all Medicaid-eligible children under the age of 21, is larger than this estimate. Furthermore, the class is fluid in that new members are regularly created.

33. All members of the class share common issues of law and fact with respect to Defendant's obligation to ensure that Washington's Medicaid eligible children are provided legally mandated Intensive HC-based Services required under the EPSDT provisions of the federal Medicaid Act, the Integration Mandate of the ADA and the Rehabilitation Act, and that such children are receiving notice of their rights under Medicaid.

34. The claims of the named Plaintiffs are typical of the claims of the class they represent.

35. Plaintiffs will fairly and adequately protect the interests of the class they represent. Plaintiffs know of no conflict of interest among the class members, and have a personal and clearly defined interest in vindicating their rights and the rights of the class members they represent to obtain necessary Intensive HC-based Services and notice of their rights under Medicaid. The relief the named Plaintiffs seek will inure to the benefit of the Plaintiff class as a whole. The Plaintiffs are represented by attorneys experienced in federal class action litigation and knowledgeable in the areas of disability and Medicaid law.

36. Prosecution of separate actions by individual class members would create a risk of inconsistent or varying adjudications with respect to individual class members which would

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establish incompatible standards of conduct or could as a practical matter be dispositive of the interests of the other members or substantially impair or impede their ability to protect their interests.

37. Defendant's ongoing actions and omissions have affected and will affect the class generally, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

VI. STATEMENT OF FACTS

A. Statutory Background

The Federal Medicaid Act and the EPSDT Mandate

38. Medicaid is a cooperative federal and state funded program authorized and regulated pursuant to Title XIX of the Social Security Act ("Medicaid Act"), providing for a medical assistance program for certain groups of low-income persons. *See* 42 U.S.C. § 1396, *et seq.* One of the purposes of the Medicaid program is to provide services to help such families and individuals attain or retain the capability for independence or self-care. *Id.*

39. State participation is voluntary; however, states that choose to accept federal funding and participate in the Medicaid program must adhere to the minimum federal requirements set forth in the Social Security Act, as amended, and its implementing regulations, 42 U.S.C. § 1396 *et seq.* Through the Medicaid program, states receive federal matching funds for their own programs in the form of reimbursements by the federal government for a portion of the cost of providing Medicaid benefits.

40. The Medicaid Act mandates that states provide Early and Periodic Screening Diagnostic and Treatment (EPSDT) services to Medicaid eligible children under the age of 21. The EPSDT mandate obligates states to ascertain children's physical and mental impairments,

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and to arrange for or provide such health care, treatment, or other measures that are necessary to treat or ameliorate impairments and conditions, 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a)(4)(B). EPSDT was created to be the "nation's largest preventative health program for children." H.R. 3299, 101st Cong. § 4213 (1989).

41. Under the Medicaid Act, every participating state must implement an EPSDT program consisting of the following services:

a. informing all persons in the state who are under the age of 21 and eligible for medical assistance of the availability of early and periodic screening, diagnostic and treatment services as described in 42 U.S.C. § 1396d(r);

b. providing or arranging for the provision of such screening services in all cases where they are requested; and

c. providing or arranging for corrective treatment the need for which is disclosed by such child health screening services. 42 U.S.C. § 1396a(a)(43).

42. Under EPSDT, states must provide and arrange for all of the treatment services listed in 42 U.S.C. § 1396d(a) for EPSDT eligible children when necessary to correct or ameliorate a psychiatric, behavioral, or emotional condition of a child or youth under the age of 21.

43. Home health care services, 42 U.S.C. § 1396d(a)(7); rehabilitative services, 42 U.S.C. § 1396d(a)(13); case management services, 42 U.S.C. §§ 1396d(a)(19), 1396n(g); and personal care services, 42 U.S.C. § 1396d(a)(24) are among the services listed in 42 U.S.C. § 1396d(a) and encompass Intensive HC-based Services. Courts have held that intensive home and community-based mental health services are covered Medicaid services that must be

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provided by the state under the EPSDT mandate *(see, e.g., Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass 2006)).

44. While states may adopt managed care concepts, contract with entities to oversee the delivery of services, and arrange services through provider networks, the states remain responsible for ensuring compliance with all relevant Medicaid requirements, including the mandates of the EPSDT program. 42 U.S.C. §§ 1396a(a)(5), 42 U.S.C. § 1396u-2; 42 U.S.C. § 1396a(a)(43). The state must ensure that the managed care entity has the capacity to offer the full range of necessary and appropriate preventive and primary services for all enrolled beneficiaries. 42 U.S.C. § 1396u-2(b)(5).

45. In addition to the EPSDT mandate, states must comply with the Constitutional Due Process requirements under the Fourteenth Amendment, the Medicaid Act's due process requirements and comparability requirements. U.S. Const. amend. XIV; 42 U.S.C. § 1396a(a)(3); 42 U.S.C. § 1396a(a)(10)(B).

The Americans with Disabilities Act and the Integration Mandate

46. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131 *et seq.*, prohibits public entities from discriminating against or excluding a qualified individual with a disability from enjoying or participating in the benefits of services, programs, or activities of the public entity on the basis of disability. 42 U.S.C. § 12132; 28 C.F.R. § 35.130.

47. Regulations promulgated to implement Title II of the ADA require public entities to "provide services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The Medicaid program is a public entity, and as such Medicaid services must be provided in the most integrated setting appropriate to the individual's needs.

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48. The United States Supreme Court has determined that unnecessary institutionalization constitutes discrimination and that Title II requires states to "provide community-based treatment for persons with mental disabilities when 1) the State's treatment professionals determine that such placement is appropriate, 2) the affected persons do not oppose such treatment, and 3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Olmstead v. L.C.*, 527 U.S. 581, at 607 (1999).

B. Washington's Delivery of Medicaid Funded Mental Health Services for Children

49. Washington has chosen to participate in the Medicaid program. RCW 43.20A.010. As a result, it receives billions of dollars every year from the federal government to fund the State's program. Indeed, approximately 50-65% of every dollar spent by the State on its Medicaid program is funded by the federal government.

50. In addition to the standard Medicaid funding received from the federal government, the State of Washington has or shall receive up to an additional $339 million from the federal government as part of an increase in the percentage of Medicaid funded pursuant to the stimulus package enacted as part of the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) ("ARRA"). These additional federal funds are designed to help states support their Medicaid programs by relieving budgetary pressure on state governments during difficult economic times.

51. States that choose to accept federal funding and participate in the Medicaid program must designate a "single state agency" to administer the Medicaid program at the state level. 42 U.S.C. § 1396a(a)(5). In Washington, DSHS is the single state agency that is designated to administer Washington's Medicaid program. Although Medicaid allows states to

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provide mandatory Medicaid services through contractors, DSHS remains responsible for ensuring that the mandates of the Medicaid Act are met, including EPSDT.

52. DSHS is authorized under state law to "make grants and/or purchase services from counties, combinations of counties, or other entities, to establish and operate community mental health programs." RCW 71.24.030.

53. The federal government has waived specific Medicaid provisions to allow DSHS to implement a pre-paid capitated mental health program for individuals with significant mental health needs. Under this capitated mental health waiver, DSHS may pre-pay fixed "capitated" amounts to geographically designated Regional Support Networks (RSNs), who in turn locally administer community mental health services to Medicaid eligible individuals who meet specific access to care standards.

54. The capitated mental health waiver does not permit DSHS to deny, reduce, or terminate services listed in 42 U.S.C. § 1396d(a) to Medicaid children for reasons not relating to each child's individual needs. The waiver only permits DSHS to provide for additional services to individuals enrolled on the waiver, although these services are not otherwise available to the general Medicaid population.

55. The capitated mental health waiver did not affect the State's obligation under the EPSDT mandate to ensure that children have access to all services listed in 42 U.S.C. § 1396d(a) if necessary to correct or ameliorate their conditions. Thus, these services must be provided regardless of whether the children's conditions otherwise meet the access to care standards applicable to the managed care program.

56. The waiver also did not affect the Defendant's obligations under the Due Process provisions of the Medicaid Act.

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57. Washington's Medicaid State Plan and capitated mental health waiver provide coverage for intensive home and community-based mental health services such as intensive care coordination, comprehensive home assessment, mobile crisis intervention, home and community-based crisis stabilization, intensive home and community-based behavioral and therapeutic services for children and their families, training on independent living, social and communication skills in a natural environment, personal care services, and respite, among other services or supports.

58. Under its capitated mental health waiver, DSHS contracts directly with independent RSNs (currently totaling 13) to administer mental health services in their communities. RCW 71.24.035(2); WAC 388-865-0200. In turn, each of the RSNs subcontract with various licensed community mental health agencies and/or health care service providers to provide mental health services to eligible recipients within each region.

59. Secretary Dreyfus's responsibilities with respect to the RSNs include, but are not limited to: 1) developing and adopting rules establishing state minimum standards for the delivery of mental health services by licensed services providers and RSNs; 2) establishing a standard contract or contracts for RSNs; 3) entering into contracts with RSNs; 4) assuring that the special needs of children and low-income persons are met; and 5) denying all or part of the funding allocations to RSNs based upon formal findings of noncompliance with the terms of the RSNs. RCW 71.24.035.

60. The RSNs' obligations include: 1) contracting as needed with licensed service providers, or in the absence of a licensed service provider entity, becoming a licensed service provider entity for the purpose of providing services not available from licensed service providers; 2) monitoring and performing biennial fiscal audits of licensed service providers who

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have contracted with the regional support network to provide services; and 3) assuring that the special needs of children and low-income persons are met. RCW 71.24.045.

61. DSHS has been aware since at least 2002 that its RSN system was failing to adequately meet the mental health needs of Washington's Medicaid children. *See JLARC 2002 Children's Mental Health Study Report 02-5, p. 9* ("This study finds that Washington has not met the Legislature's intent to establish a coordinated, efficient and effective system of public mental health care for children"). Yet, the State has taken no action to correct this failing. Indeed, as recently as April 2009, another report prepared for DSHS described the RSN system as "a system that has high levels of regional variation, limited access to care, a lack of standardized care management and unclear roles and authority between state agencies, the RSNs and some of the provider systems." *See Improving Care: Options for Redesign of Washington's Mental Health System* (April 2009).

62. DSHS has similarly known for years that many of Washington's Medicaid children are not receiving the Intensive HC-based Services they need and that these children are underserved by the limited array of mental health services made available to them. Repeatedly, DSHS has received and generated reports confirming and reiterating the State's ongoing failure to provide Intensive HC-based Services, and the resulting harm to Washington's children. For example:

a. *Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds Final Report* (November 2004). As early as 2004, DSHS acknowledged that community-based services are essential to prevent harm to children:

> "The expansion of community based services for children and adolescents is essential to minimize the need for foster care, residential,

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or inpatient services as well as to promote effective integration back into the community once an individual has left any of these treatment alternatives…Community based services can minimize these disruptions and the corresponding risks (e.g. trauma from separation) that may occur with inpatient and residential treatment options while also offering effective outcomes and comparatively lower cost of care."

b. *Children's Acute and Non-Acute Inpatient Psychiatric and Residential Treatment White Paper* (August 2006). This DSHS white paper contained the following stark conclusions:

1) "Program shortages and inconsistencies in local community (RSN) intensive community-based care and diversion resources [to divert children from institutionalization] result in acute community hospitalizations and for those who do not improve, or frequently decompensate, the need for Children's Long-Term Inpatient Programs (CLIP);" and

2) "The same shortages in community based alternatives that increase the need for CLIP admissions, result in lengthened stays when there are few or no "step-down", or intermediate care resources for youth and their families to utilize post-discharge [from a CLIP facility]."

c. *CLIP System Improvement Workgroup* (September 2007). This workgroup paper documented similar observations about the delivery of community mental health services to children:

1) "Adequate assessments are not available to quickly access intensive services to prevent long term treatment;"

2) There is "[l]imited coordination, policy and agreement among service providers/systems;"

3) There is a "[l]ack of effective coordination for pre & post services [for children before and after they are institutionalized];"

4) There is "[n]o aftercare in the community including discharge planning by/with allied systems;"

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5) There are "[p]rogrammatic limitations in meeting each child's needs;" and

6) "[The] System[s] needs [are] placed over child and family needs."

d. *Intensive Children's Mental Health Services Summary Report* (Fall 2009). In this report DSHS's Mental Health Division identified several significant problems with its delivery of mental health services for children, including:

1) "a limited array of intensive community and family-based services for children and youth;"

2) "insufficient transitional programs to support successful returns to the community;" and

3) "insufficient targeted treatment and security options for special populations such as youth with co-occurring developmental disabilities and mental health needs, and highly aggressive youth."

To address these issues, a workgroup consisting of DSHS officials and other stakeholders recommended expanding transition and aftercare services for children being discharged from CLIP facilities and 24/7 mobile and in-home crisis services connected to longer-term stabilization beds.

e. *Children's Mental Health Services – Synopsis on Gaps and Recommendations related to SSHB1088 from DSHS Assistant Secretaries and Administrators* (2009). Most recently, DSHS issued a document related to SB 1088 to identify gaps in Children's Mental Health services. In the document DSHS acknowledged that the "Frequency, duration, and type of [mental health] treatment modality offered [to Washington's Medicaid children] are inappropriate and/or limited,"

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and "Wraparound, respite, crisis mobilization, day treatment and integrated dual disorder services are not available especially in rural areas."

63. Despite such information and notice, the Defendant has failed to take adequate actions providing or arranging for the Intensive HC-based Services children in Washington need and are not receiving, despite the legal mandate to provide for such services, her knowledge of the deficiencies within DSHS's mental health system for children, her receipt of recommendations for how to improve the system, and the long standing acknowledgment by DSHS that the lack of intensive services results in trauma for children.

64. In many areas of Washington, children with mental health needs who are on Medicaid only receive weekly therapy and medication management. Children who cannot safely remain in their own homes with these limited services and without necessary Intensive HC-based Services must turn for help to acute care hospitals such as Fairfax, Children's Hospital, Kitsap Mental Health, and Sacred Heart, where they are placed on locked child and adolescent psychiatric wards.

65. Some of the children who cycle in and out of these acute care facilities are eventually placed in one of four Children's Long term Inpatient Psychiatric ("CLIP") facilities located in Lakewood, Tacoma, Seattle, and Spokane. CLIP services are administered by DSHS. These facilities are often hundreds of miles away from the child's home and family, which causes harm of prolonged separation and creates significant barriers to providing necessary family therapy, discharge planning, and services to reintegrate children back into their home and communities.

66. While the State and the RSNs offer some limited home and community-based services, these services are made available only to a fortunate few and the limited services that

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are offered are often subject to arbitrary limits and onerous, if not draconian, restrictions. For example:

a. The few existing Medicaid funded in-home supports and case management programs have limited slots and have narrow access standards which require that a child's mental health condition meet a certain level of severity, which is narrower than the "necessary to correct or ameliorate" standard for EPSDT. This results in many children having to deteriorate in order to get the care they need. If a child is able to access these services, the services are often limited by arbitrary caps and restrictions unrelated to the child's needs.

b. In some areas of Washington, more intensive services may be available through Washington's foster care system, but in order to access these services parents of Medicaid children must first give up their custodial rights.

c. In other regions of the State, children can only access necessary intensive mental health interventions if they have been charged or found guilty of a crime through the local and state juvenile justice system.

d. While Washington has implemented a few pilot programs around the state to provide community-based supports, these pilot programs have limited capacity, are not funded with Medicaid, and are not treated as a Medicaid entitlement. The pilot programs reach only a reported 79 children, resulting in a very small percentage of children who are able to access limited services—largely based upon where they happen to live.

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67. Some services, such as community-based therapeutic mentoring and intensive mobile crisis stabilization services, are routinely unavailable to children on Medicaid in much of the state.

68. Children served by the mental health system do not get notice of their right under EPSDT to request and receive services necessary to correct or ameliorate their conditions. DSHS's contracts with the RSNs only require that each RSN provide Medicaid recipients under the age of 21 with a copy of the "Mental Health Benefits Booklet" published by DSHS. This publication does not adequately inform children and their families that Intensive HC-based Services are available under EPSDT. Consequently, many families are poorly positioned to request services their children need because they do not know that these mental health services are coverable by Medicaid. *See DSHS Report, Children's Mental Health Gaps Response, Summary of Findings Across Data Sources* (2007) (identifying lack of information to families as a major barrier to effective access to services).

69. Children and their families do not receive prior written notice when the Community Mental Health Agency denies, reduces or terminates Medicaid services, nor do they receive any notice that they have a right to request a hearing to challenge such denials, suspensions, reductions, and terminations of their mental health services.

70. The DSHS website states that recipients only receive action notices if their services are denied, suspended, reduced, or terminated when such action is made by the RSN, and not the result of a community mental health agency decision. If a community mental health agency decides to deny, suspend, reduce, or terminate Medicaid services, DSHS has no adequate regulations, policies, or procedures requiring providers to ensure recipients' of their due process rights.

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C. The Plaintiff Children's Experience with Washington's Public Mental Health System

Currently Institutionalized Children

T.R. (Ten-Year-Old Boy)

71. T.R. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services he needs to correct or ameliorate his mental health conditions or reduce his behavioral symptoms.

72. Since T.R.'s single mother died when he was six years old, T.R. and his brother have lived with their older sister, R.R., who is T.R.'s legal guardian and next friend. R.R., a single mother, also cares for her seven year-old son.

73. T.R. has had serious behavioral symptoms since his mother's death in 2005. In 2008, after his symptoms worsened, T.R. was diagnosed with Oppositional Defiant Disorder, Attention Deficient Hyperactivity Disorder, and Mood Disorder Not Otherwise Specified. In the last two years, T.R. has been admitted into the psychiatric unit of the community hospital on four occasions. Due to his inability to access necessary services, T.R. is currently institutionalized at the state psychiatric hospital for children on the grounds of Western State Hospital.

74. T.R.'s symptoms have not improved, and his hospital treatment team has indicated that the institutionalized setting in which he is receiving services is harmful to him. The team recommended that T.R. be discharged to his sister's home with intensive home and community-based mental health services that were not available to him prior to his admission to the state hospital.

75. Prior to his most recent institutionalization, T.R.'s Care Plan included one-to-one in-home "case aid" services and mobile crisis services.

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76. When T.R.'s symptoms escalated, his sister called the crisis team for help, but on multiple occasions there either was no response or the crisis team refused to come to T.R.'s home and instructed his sister to call the police. The crisis services were only approved for 30 days at a time, so T.R. and his sister had no assurances that crisis services would be available to T.R. when the next crisis arose.

77. By November 2008, after T.R. was hospitalized again in an acute psychiatric unit. His community treatment team recommended that his one-to-one in-home "case aid" services be increased to over 40 hours per week. His records documented that the "case aides" were "helpful" to address T.R.'s symptoms and in "keeping his life consistent." However, by the end of December 2008, T.R. had met the funding cap the RSN had set for in-home "case aid" services. Although T.R. continued to need these services to help manage his symptoms, the "case aides" were terminated.

78. T.R.'s therapist requested an exception to the RSN's policy for him to continue receiving case aids or to allow a brief stay at a residential facility, but her request was denied. T.R. later began receiving some additional case aid services but at a significantly reduced level of only 20% of the hours he had been receiving.

79. With these inadequate services, T.R.'s mental health continued to decline and T.R. was admitted to the state psychiatric hospital for children in February 2009. While initially successful after his admission, T.R.'s condition soon quickly deteriorated. In October 2009, T.R.'s hospital treatment team informed his sister that they believed the hospital was not the appropriate environment to treat his mental health needs. Specifically, the team identified the rotation of clinical residents that occurs in a teaching facility and the turn over of patients at the hospital as a source of continual trauma that was detrimental to treating T.R. His treatment team

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concluded that these inherent aspects of the state hospital program were harming T.R. and undermining his recovery. T.R.'s treatment team has recommended discharge back to his sister's home based on their conclusion that a stable family home is clinically more appropriate.

80. To manage T.R.'s symptoms in the community, where T.R. must receive treatment in order to achieve greater emotional stability and move toward a productive future, T.R. will need more intensive and long-term mental health services and supports in his home and community than he had before his hospital admission.

81. If T.R. were provided with adequate and appropriate Intensive HC-based Services, he would improve significantly and be able to live at home with his family rather than at the children's psychiatric hospital on the grounds of Western State Hospital. Without these services, T.R. has little hope of avoiding worsening symptoms, harm to himself or others, repeated hospitalizations, continued institutionalization, and separation from his family.

82. Prior to T.R.'s recent institutionalization, R.R. sought intensive home and community-based services for T.R. through Medicaid and believed that the services provided by the RSN were the maximum allowable under Medicaid. She never received notice of the availability of Intensive HC-based Services under the Medicaid program or T.R.'s right to a fair hearing to dispute the denial, reduction, and termination of services.

S.P. (16-Year-Old Girl)

83. S.P. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services she needs to correct or ameliorate her mental health conditions or reduce her behavioral symptoms.

84. S.P.'s current diagnoses include Schizophrenia, paranoid type, and Attention Deficit Hyperactivity Disorder. As a result of her conditions, she hears voices, has visual

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hallucinations, experiences paranoid delusions that her family members want to harm her, is irritable, and displays aggression, depression, and low self-esteem. She is currently institutionalized and has been denied the Intensive HC-based Services that she needs to correct or ameliorate her mental health conditions.

85. S.P. has been exhibiting mental health symptoms since she was in kindergarten. She struggled in school, had multiple truancies, and was ultimately unable to cope in a school environment for more than two hours a day.

86. In 2005, S.P. participated in a five week facility-based day treatment program at a local community hospital in Spokane, Washington. Even after completing this program, S.P. was subsequently involuntarily hospitalized seven times in the psychiatric unit of the local hospital, and was twice involuntarily committed for long term treatment at a CLIP facility approximately 300 miles away from her home. At the end of each stay, she was discharged to the same inadequate array of weekly therapy, medication management, and case management services that had failed her in the past. During this time, S.P. was not offered or provided any additional Intensive HC-based Services to help cope with, control, or reduce her symptoms.

87. The second time S.P. was discharged from the Tacoma CLIP facility in June 2009, her treating mental health professional recommended specific home and community-based mental health services and identified as "essential services" the provision of one-to-one home-based, independent living and social skills training, enhanced supervision support during early evening unstructured time, and community-based training in the development of coping skills.

88. After discharge, S.P. requested these services but was told they were not available. S.P.'s services were again limited to the weekly office-based therapy and medication

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management by a psychiatric nurse that she had received after every prior unsuccessful discharge.

89. S.P.'s condition again deteriorated over the summer of 2009. She began to experience command hallucinations, was afraid to accept medication from her mother, and began threatening others in response to her hallucinations. As a result, she was again involuntarily committed to the local community hospital's psychiatric unit.

90. When S.P. was discharged from the hospital on September 11, 2009, she was approved for one of two slots in a new program in Spokane, Washington, that promised her more home services. However, the services available through this program were also inadequate to satisfy the recommendations of her treating mental health professional. For example, S.P. could not access a sufficient number of service hours or services during the times when her mother was at work.

91. Although S.P.'s treating mental health professional was concerned that another institutionalization would not be in her best interest, she ultimately recommended that S.P. return to a CLIP placement due to the lack of sufficient Intensive HC-based Services. In October 2009, S.P. was involuntarily ordered to the state children's psychiatric hospital on the grounds of Western State Hospital, hundreds of miles from her home and family.

92. If S.P. were provided with adequate and appropriate EPSDT mental health services, she would improve significantly and be able to live at home with her family. In order to ameliorate S.P.'s condition and avoid further institutionalization, S.P. needs and has requested the Intensive HC-based services recommended by her treating mental health provider. These essential services have not been made available to her, and as a result, she has experienced an

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increase in her symptoms, has harmed herself and others, and has become socially isolated by recurring or prolonged institutionalization.

93. S.P. and her mother never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about her right to request a hearing to dispute denials, reductions, or terminations of her services.

C.A. (15-Year-Old Girl)

94. C.A. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services she needs to correct or ameliorate her mental health conditions or reduce her behavioral symptoms.

95. Prior to entering adolescence, C.A. demonstrated no mental health needs and was an honor roll student. However, by the time she was 14 years old, she had been hospitalized three times due to depression and suicide attempts, had begun cutting herself, and had jumped out of a second story window.

96. C.A.'s mental health diagnosis is Major Depressive Disorder.

97. C.A.'s first hospitalization was for thirteen days in December 2007. Upon discharge, C.A. received recommendations for medication management and individual and family therapy.

98. By February 2008, C.A. was again hospitalized. She was discharged one week later with recommendations that she continue outpatient therapy, specifically cognitive behavioral techniques for managing depression and anxiety, interpersonal therapy and distress tolerance. Additional recommended services included parent support, coaching and education for C.A.'s mother to assist her in effectively dealing with C.A.'s emotional instability and chronic suicidal ideation in the home setting.

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99. Despite her two hospitalizations within ten weeks, no comprehensive home-based assessment was completed to determine what services C.A. needed.

100. Upon discharge from the hospital in February 2008, C.A. did not receive Intensive HC-based Services, nor was she assessed for such services. Instead, C.A.'s mother was referred to the abuse and neglect system to access in-home services that should have been provided for under Medicaid, and to apply for the Children's Hospital Alternative Program ("CHAP"). C.A. was not able to access these services for several months.

101. Without the Intensive HC-based Services she needed, C.A. continued to experience serious depression and hopelessness after discharge. Two months later, in April 2008, C.A. jumped from a second story window and was re-admitted to the psychiatric hospital. Upon discharge, C.A. again continued to receive only limited mental health services, specifically medication management and therapy.

102. On September 25, 2008, C.A. went to the emergency room at the local community hospital complaining of seeing shadows and fairies, and hearing footsteps. She was not admitted and did not receive Intensive HC- based Services.

103. In November 2008, C.A. was enrolled in the CHAP. This program was supposed to provide Intensive HC-based Services but the services she actually received were inadequate. The services C.A. received in the CHAP program were: a) individual therapy at the office of the community mental health agency - over an hour's drive from her home; b) weekly in-office family therapy that was attended by C.A.'s mother while C.A. was in her individual session; and, c) medication management to stabilize her mood. C.A. also attended a few "therapeutic photography" sessions with a technician at the community mental health agency and on a few occasions, had a "case aid" take her on a short visit to a local coffee shop.

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104. C.A. was offered out-of-home respite through therapeutic foster care as an intermediary step to prevent acute hospitalization. On the one occasion she attempted to use this service, she became distressed and had to return home in the middle of the night.

105. Notably, the reported goal of C.A.'s CHAP services was to "work with [her mother] in maintaining C.A. in her home until a CLIP comes through." The service was not intended as an alternative to a CLIP inpatient treatment or to avoid institutionalization.

106. C.A. entered a CLIP facility in May 2009. She has worked hard with her treatment team and met benchmarks set for her. She is described as a "star" in group therapy and has maintained high levels in the facility's reward system.

107. C.A.'s mother travels the 63 miles each way from their home in Island County to the CLIP facility twice a week to attend family therapy sessions and visit her child. Facility based family therapy sessions have had limited effectiveness.

108. C.A. is a very bright child and is capable of advanced academic work. However, opportunities for her to receive accelerated educational services at the CLIP have been limited. C.A. sees her intelligence as a strength she can build on, and experiences hopelessness when she cannot do challenging academic work.

109. C.A.'s mother is deeply committed to support her child's recovery and bringing her home. However, the local mental health agency did not provide sufficient services to C.A. prior to her admission and C.A. must have Intensive HC-based Services to be safe at home.

110. C.A. never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about her right to request a hearing to dispute denials, reductions, or terminations of her services.

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Children Discharged from Institutions Not Receiving Adequate Services

T.F. (15-Year-Old Girl)

111. T.F. is a Medicaid recipient who is not receiving the intensive home or community-based mental health services she needs to correct or ameliorate her mental health conditions and reduce her behavioral symptoms.

112. T.F. has been diagnosed with Bipolar Disorder, Oppositional Defiant Disorder, and Post Traumatic Stress Disorder. As a result of her psychiatric disorders and history of sexual abuse by a non-parent, she exhibits severe symptoms of anxiety, including self-harming behaviors.

113. When T.F. was ten years old, she had two suicide attempts that resulted in inpatient treatment at her local hospital's psychiatric unit. Based on these incidents, DSHS's Division of Child and Family Services (DCFS) took custody of her. Both T.F. and her father want her to return to her father's home, but DCFS continues to have custody because T.F. needs Intensive HC-based Services that have not been made available to her outside of the foster care system.

114. In October 2008, T.F. was briefly returned to her father after receiving a year of inpatient psychiatric treatment at the CLIP facility in Spokane. At discharge, the treatment team at the CLIP recommended that T.F. receive individual counseling, individual and family sessions to transition home, group therapy, and structured recreational activities to model appropriate behaviors.

115. T.F.'s discharge plan included medication management, individual counseling, twelve hours per week of therapeutic aids and transitional counseling services from the CLIP

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facility. T.F. did not actually receive these services due to inflexible service hours and a lack of available and qualified therapeutic aid providers.

116. No group therapy or structured recreational activities was offered. T.F. also has not been provided mobile crisis services or home based crisis stabilization services to respond when her symptoms escalated. During this period, T.F. was hospitalized, arrested, and expelled from school for such things as threatening to overdose on her prescription medications and getting into altercations with other students.

117. Faced with a lack of insufficient services, T.F. was institutionalized again at the CLIP facility in January 2009. When T.F. was ready for discharge from the CLIP facility in May 2009, she asked to return home to her father. However, she was advised that the structured supports T.F.'s treatment team recommended for her were only available in a congregate care facility. DSHS placed T.F. in a treatment facility in Coeur D'Alene, Idaho and told her that she had to complete the program in order to return home to her father.

118. While she was in Coeur D'Alene, the facility relied on law enforcement to address her mental health crises: T.F. was arrested eight times and spent the vast majority of the time between May and October 2009 in the local Juvenile Detention Center. As a result of her repeated arrests and incarcerations, the institution did not implement T.F.'s treatment plan or provide T.F. with the family and individual therapy she needs. Ultimately, the facility discontinued services, leaving her in the custody of Idaho's juvenile criminal system.

119. T.F. requested to go home with her father and for services to be delivered to her in her father's home, but DSHS did not make any arrangements for her to receive services at home. T.F. needs to be in a stable setting long-term with Intensive HC-based Services.

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120. T.F.'s DCFS case manager reports that he is unable to find a therapeutic group home or foster home in the Spokane area. T.F. has stated that being away from her family is a primary source of stress and anxiety for her. Nonetheless, in November 2009, T.F. was moved to the closest community placement option for her in Washington – a foster care placement in Kennewick, 155 miles away from her family.

121. T.F.'s father is committed to visitations and family therapy, knowing that these will help T.F. recover, but fears that the great distance between his home and the foster care home will result in less frequent contact with her. T.F.'s father has limited resources to pay for regular travel, has an inflexible schedule on his job, and is concerned about the impact of the upcoming winter on his ability to travel such a distance.

122. T.F. is currently being harmed by her separation from her family and the lack of services. Without the availability of Intensive HC-based Services in her own community, T.F. is at risk of further harm from the separation of her family, institutionalization, incarceration, and an increase in her behavioral symptoms.

123. T.F. never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about her right to request a hearing to dispute denials, reductions, or terminations of her services.

P.S. (17-Year-Old Boy)

124. P.S. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services he needs to correct or ameliorate his mental health conditions or reduce his behavioral symptoms.

125. P.S. has been diagnosed with severe Post Traumatic Stress Disorder (Primary), Bipolar Disorder Not Otherwise Specified, Attention Deficit/Hyperactivity Disorder Not

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Otherwise Specified, and Fetal Alcohol Syndrome. P.S. was abused during the first eight years of his life. As a result of his mental health conditions and his traumatic childhood, P.S. experiences traumatic flashbacks, sleep problems, headaches, and problems concentrating. P.S. also exhibits severe symptoms of suicidal attempts, and self harming behaviors that include cutting himself, burning himself, and banging his head.

126. P.S. came to live with his grandmother at the age of eight. During the years he lived with her in Yakima County, the only community mental health services he could access were in-office counseling and medication management. With these limited services, his symptoms did not improve. He attempted suicide, experienced a series of school expulsions, arrests, and involuntary hospitalizations.

127. Beginning with his involuntary commitment in October 2007, P.S. was moved between numerous out-of-home placements, including the CLIP facility in Spokane, crisis response centers in Yakima and Kennewick, and the psychiatric unit of the community hospital. In November 2008, P.S. was discharged from the CLIP facility with the following recommendations: placement in a therapeutic foster home with respite care; specialized school setting; behavioral health specialist to provide one-to-one attention; monitoring during unstructured times; and development of a behavioral plan.

128. Upon discharge, P.S.'s Yakima treatment team had identified no placement options. P.S. did not receive the services recommended by the CLIP facility, and instead was discharged to a crisis bed in Yakima without any one-to-one support. P.S. ran away the first weekend and was missing for several days.

129. In December 2008, the Casey Family Foundation agreed to fund a six-month treatment program in Marylhurst, Oregon. P.S. was discharged from the facility in late May

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2009 with the following recommendations: highly structured group home setting; independent living skills training, mental health therapy, crisis support and medication management; discharge placement familiar and sensitive to the effects and reactions to trauma.

130. Upon return to Washington, P.S. did not receive the services that were recommended for him by his treating mental health professionals.

131. From May until August 2009, P.S. again rotated between temporary placements while his Yakima based treatment team struggled to identify a placement that would accept him. During this period, P.S. was not provided with a comprehensive home assessment or mental health therapy, and received only sporadic medication management.

132. Fearing for P.S.'s safety and hoping that there would be more mental health services in King County, P.S.'s grandmother sent him to live with his biological mother in Seattle in August 2009. P.S. requested mental health treatment in King County, but was initially denied because his Medicaid coupon was from another county. After obtaining a King County medical coupon the following month, P.S. completed the intake process at a community mental health agency in King County, Washington on September 23, 2009.

133. P.S. made multiple requests for an appointment with a psychiatrist to check his medication levels and physical tolerance of the six different medications that had been prescribed by the Oregon facility. However, P.S. has yet to meet with a psychiatrist. P.S.'s community mental health provider directed P.S. to see his family doctor for monitoring of his psychotropic medications during the delay.

134. The only services P.S. has been able to access at his community mental health agency in King County are weekly counseling in the therapist's office

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135. P.S. has requested other necessary services, including mobile crisis stabilization services, home behavioral assessments and aids, therapeutic mentoring, but none of these services have been made available to him. P.S. was informed that he would be put on the waiting list for "wrap around" case management services and parent support.

136. P.S. has experienced five separate mental health crisis events since coming to Seattle in August, including one event of suicidal ideation and four physical altercations with the youth in his community. His counselor has been notified of these incidents and has acknowledged that P.S. should not be left unsupervised. However, the services P.S. needs and has requested have not been provided for or arranged by the Defendant.

137. P.S. is experiencing harm due to the lack of services. For example, after a recent mental health crisis, P.S.'s mother was informed by the apartment complex in which they live that they were going to be evicted because of P.S.'s actions. P.S. and his family had to scramble to find a new home. During the turmoil, P.S. received no mental health therapy services from his community mental health provider.

138. Without necessary Intensive HC-based Supports, P.S. is experiencing increased symptoms. He is socially isolated from his peers, has experienced physical injuries, and has been suspended from school. If P.S.'s needs continue to go unmet, he will continue to be at risk of experiencing an increase in his symptoms, additional physical injuries, incarceration, and additional long-term institutionalizations.

139. P.S. never received notice of the availability of Intensive HC-based mental health services through the Medicaid program, or a notice about his right to request a hearing to dispute denials, reductions, or terminations of his services.

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T.V. (11-Year-Old Boy)

140. T.V. is a Medicaid recipient who is not receiving the intensive home or community-based mental health services he needs to correct or ameliorate his mental health conditions, or to reduce his behavioral symptoms.

141. T.V. has been diagnosed with Mood Disorder, Not Otherwise Specified; Post Traumatic Stress Disorder, chronic; Oppositional Defiant Disorder, chronic; and Attention Deficit Hyperactivity Disorder, inattentive type. As a result of his conditions and traumatic history, T.V. displays severe symptoms of aggression, sudden outbursts of rage, elopement, and self-harming behaviors. T.V. continues to have difficulty concentrating and socializing appropriately with peers.

142. Before his second birthday, T.V. was removed from his biological parent's home due to severe neglect, and bounced between five different placements until he was finally placed with C.D. as a foster child. When T.V. was seven-years-old, after he had bonded with C.D. and her family, but before C.D. had established third party custody, he was transferred to a different foster home for fifteen months where he was the victim of sexual assault.

143. Following T.V.'s return to C.D.'s custody at age eight, T.V. began to exhibit severe symptoms of a serious mental health condition. T.V. was hospitalized at the local community hospital's psychiatric unit five times over the next eighteen months, and received day treatment through the hospital's outpatient program and at a community mental health provider. Without adequate mobile crisis services, he had incidents in which he was arrested and detained. Ultimately, T.V. was institutionalized for over a year at the state psychiatric hospital for children on the grounds of Western State Hospital in Lakewood, WA, 300 miles away from his home and family.

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144. When T.V. was discharged from the state children's hospital in August 2009, the hospital's treatment team recommended "significant support as an outpatient in the school and home setting" as well as individual and family therapy in order to continue his progress and "prevent further hospitalizations."

145. Upon discharge, T.V. was enrolled at a local community mental health provider so that he could receive case management services, and was offered weekly office-based therapy, an anger management group, and monthly medication management check-ups. C.D. repeatedly requested "step-down" transitional services, including community-based therapeutic mentoring and in-home behavioral aids to help T.V. practice the de-escalation skills he learned at the state hospital in a natural environment.

146. T.V.'s current case manager informed C.D. that she agreed the services C.D. requested would clinically benefit T.V., but advised that these services are only made available to children with more severe symptoms. As a result, T.V. could not access the services he needed to succeed in his community, to prevent his condition from worsening again, or to reduce his symptoms of Post Traumatic Stress Disorder.

147. Denied the Intensive HC-based Services he needs, T.V.'s symptoms have worsened over the last few months to the point that he recently threatened to jump out of a window to commit suicide. Prior to the onset of these symptoms, the services that could have prevented his condition from worsening were unavailable to him. His case manager has now referred T.V. to a program that provides in-home services, but he has not yet been approved and has been told that there is a waiting list.

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148. If T.V. does not receive services to prevent his condition from worsening again, he is at risk of harm from himself and at risk of being re-hospitalized and separated from his family again.

149. T.V. never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about his right to request a hearing to dispute denials, reductions, or terminations of his services.

G.B. (13-Year-Old Girl)

150. G.B. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services she needs to correct or ameliorate her mental health conditions or reduce her behavioral symptoms.

151. G.B. was removed from her birth mother when she was 17 months old due to severe neglect. G.B. was placed in multiple foster homes before coming to live with her adoptive family at age 24 months. G.B. has exhibited troubling behavior from the onset, such as destructive behavior, refusing to be held or touched and an inability to self-soothe or be comforted.

152. G.B. has been diagnosed with Oppositional Defiant Disorder, Mood Disorder Not Otherwise Specified, Reactive Attachment Disorder, disinhibited type, Attention Deficit Hyperactivity Disorder, combined type, and Post Traumatic Stress Disorder.

153. By age 11, G.B. had received inpatient mental health treatment on five different occasions. Soon thereafter, G.B. was admitted to the state psychiatric hospital for children on the grounds of Western State Hospital, and remained there for almost two years. G.B.'s prognosis at discharge in late June 2009 was "guarded."

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154. Upon discharge from the state hospital, G.B.'s treatment team made a series of discharge recommendations that were to form the core of G.B.'s community treatment; specifically:

a. Dialectical Behavioral Therapy (a specific form of individual therapy);

b. Line-of-sight supervision, particularly in the home to ensure the safety of younger siblings;

c. Community crisis plan, with out of home emergency respite if needed;

d. A paraprofessional to work with the family on skill building and behavioral interventions;

e. Ongoing family therapy with a skilled professional;

f. Community groups and activities for G.B. to develop social skills in less structured settings, while supervised by adults; and

g. Ongoing group therapy.

155. Upon discharge, G.B. planned to receive mental health services through the RSN in King County. G.B. was eligible to access some intensive services from multiple providers for crisis response services, respite services, case aides, and individual therapy. However, the RSN did not provide her with Dialectic Behavioral Therapy, group therapy or support for community group activities.

156. G.B. came home on June 25, 2009 and was stable in her home with the intensive services available. From July through October, G.B. had access to approximately 20 hours of one-to-one therapeutic "case aid" services per week, and her therapist came to her home for weekly sessions. While there were a few incidents of G.B. engaging in problematic behavior, such as opening car doors while the car was moving, her parents maintained line-of-sight

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supervision and were assisted in this by the in-home one-to-one case aids. G.B. was able to access some out-of-home respite.

157. On October 28, 2009, G.B.'s mother received a call from the RSN contractor who provided GB's case aid services. She was notified that beginning November 1, 2009, the case aid services would be terminated. G.B. and her parents received no pre-termination written notice from the RSN or other providers, and they were not informed of the process to dispute the termination through a fair hearing.

158. On October 29, 2009, G.B.'s treating therapist made specific recommendations for needed services for G.B. to the RSN. These services included individual therapy, crisis services, continued "line-of-sight" supervision and related one-to-one therapeutic services to address G.B.'s tendency to target her younger siblings, family therapy, social group therapy, and modification of her treatment plan to receive more services in the home.

159. "Case aid" and other services were terminated as of November 4, 2009. G.B. currently receives individual therapy sessions for 50 minutes once per week and no other services.

160. The summary removal of these necessary EPSDT services, without notice or opportunity to appeal in time to avoid the disruption, places G.B. at risk of deterioration, and reinstitutionalization. Over the past few weeks, G.B.'s oppositional behavior and threats of self-harm have increased, to the point where her mother recently notified G.B.'s therapist that G.B. may soon need to return to a CLIP facility.

161. Without Intensive HC-based Services, G.B. has little hope of receiving the necessary treatment she needs to avoid suffering an increase in symptoms, harm to herself or

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others, repeated hospitalizations, long-term institutionalization, incarceration, and separation from her family.

162. G.B. never received notice of her right to request a hearing to dispute denials, reductions, or terminations of her services.

Children Never Institutionalized

E.H. (15-Year-Old Boy)

163. E.H. is a Medicaid recipient who is not receiving the intensive home and community-based services he needs to correct or ameliorate his mental health conditions and reduce his behavioral symptoms.

164. E.H. has been diagnosed with Bipolar Disorder, Attention Deficit Disorder, Oppositional Defiant Disorder, and has violent behavioral symptoms. E.H.'s mood cycles between manic phases characterized by racing and grandiose thoughts and phases in which he is depressed and explicitly articulates a wish to die. He makes threats and attempts to commit suicide, and has injured himself on numerous occasions by hitting and cutting himself.

165. E.H.'s symptoms have been documented since he was a toddler. By the time he was four-years-old, E.H. was taking medications to manage his behaviors, had therapeutic aid services, and was in counseling.

166. Between 2004 and 2006, E.H.'s condition began to worsen. In March 2005, E.H.'s symptoms escalated to the point his mother called the police, and he was arrested and detained in juvenile detention. His provider began recommending out-of-home placements, but his mother chose not to give up custody.

167. In February 2007, E.H. was hospitalized at an acute psychiatric hospital in Spokane, Washington after threatening to kill his parents and to harm himself. He was

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discharged with a plan to receive counseling from the community mental health provider in Whitman County.

168. In November 2008 the acute psychiatric hospital in Spokane admitted E.H. for inpatient treatment. The hospital did not have a pediatric bed for him and transferred him to an acute psychiatric hospital in Coeur D'Alene, Idaho. When he was discharged on December 5, 2008, his plan specified that he was to receive "comprehensive wraparound services" from his mental health provider in Whitman County. This plan included necessary services that he did not receive. Specifically, he never received "one-on-one individual social skills, education, and coaching," or assistance from the community mental health provider in becoming integrated into "community based social activities".

169. Until he was most recently hospitalized, E.H. was receiving weekly therapy, medication management from a psychiatrist two hours away, and respite services. E.H. was not receiving any in-home behavioral services, and his crisis services were generally limited to telephone consultations and emergency room visits, despite his persistent self-harming and aggressive behaviors.

170. In October 2009, E.H. was re-admitted to the acute psychiatric hospital in Coeur D'Alene, Idaho after he attempted to commit suicide. Fifteen days later, he was discharged with recommendations to follow up with the local community mental health provider.

171. In order to be successfully discharged home, he needs Intensive HC-based Services. If E.H. does not receive these services, he is at risk of long term institutionalization or suffering significant injuries or death at his own hands.

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172. E.H. never received notice of the availability of intensive home and community-based mental health services through the Medicaid program, or a notice about his right to request a hearing to dispute denials, reductions, or terminations of his services.

E.D. (10-Year-Old Boy)

173. E.D. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services he needs to correct or ameliorate his mental health conditions or reduce his behavioral symptoms.

174. E.D. has been diagnosed with General Anxiety Disorder, Attention Deficit Disorder, and Oppositional Defiant Disorder, and a possibility of Bipolar Disorder.

175. Beginning when E.D. was four-years-old, he experienced multiple removals from his mother's custody and experienced incidents of sexual abuse by a non-relative. E.D.'s mental health conditions and traumatic history of abuse and separations from his family have resulted in E.D. experiencing significant symptoms of aggression, sudden outbursts of anger, and self-harming behaviors. His symptoms are on a rapid "cycle" in which they tend to dramatically worsen and get better about every five days.

176. In June 2009, E.D. received an outpatient psychiatric evaluation at his local community hospital's psychiatric unit. These recommendations included further evaluation for autism spectrum disorder, "appropriate crisis interventions" and "intensive home interventions, as well as wraparound services and case management."

177. In August 2009, E.D.'s mother learned that E.D. had still not been placed on the waiting list for an autism assessment when she has requested it back in December 2008, and so she made another request. E.D. did not receive this assessment until November 19, 2009 and has yet to receive results.

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178. In August 2009, E.D.'s mother attempted to access services during an episode when E.D.'s behavioral symptoms escalated to the point where she had serious safety concerns. She was told by the community mental health agency to take him to the emergency room or to call "9-1-1" if she needed help getting him there. At the hospital, E.D.'s mother requested inpatient treatment, but was turned away without any other immediate services.

179. In August 2009, the local community mental health agency in King County conducted an intake assessment. E.D.'s mother reported that E.D. has symptoms of anger and aggression that were so severe that he assaulted and threatened to kill her and his brother and destroy their property. The assessment resulted in the mental health professional requesting a benefit of "3A1 Tier" for E.D., which is the second to highest level of outpatient services available. E.D.'s mother never received any written notice that he had been assessed at this level of care, what services were included in this level of care, what other services were available from the mental health agency or Medicaid, or how the agency determines who can access these services.

180. Currently, E.D. only receives weekly office-based therapy, and monthly medication management appointments at the community mental health agency. He is not receiving and has not been offered any Intensive HC-based Services including the "appropriate crisis interventions, intensive home interventions as well as wrap around services and case management" recommended by the community hospital in June 2009.

181. E.D.'s mother requested Intensive HC-based Services from her Medicaid provider, but she was told the mobile crisis intervention, wraparound, and behavioral testing she requested are not available. She did not receive any written notice of a denial. The provider told E.D.'s mother he would be referred to their more intensive program for additional services, but

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she has not received any further information about whether the referral was made, what services could be available to E.D. in that program, or whether E.D. has been approved.

182. Without necessary mental health services, E.D.'s symptoms have not improved. As a result of his behavioral symptoms, he has significant difficulties in school, has been suspended on multiple occasions, and is at risk of expulsion. If E.D. does not receive the treatment he needs, E.D. will continue to be at risk of being removed from his home due to his undertreated impulsive and aggressive behaviors that place him at significant risk of getting arrested, hospitalized, or institutionalized in a long term facility.

183. E.D. has never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about his right to request a hearing to dispute denials, reductions, or terminations of his services.

L.F.S. (9-Year-Old Boy)

184. L.F.S. is a Medicaid recipient who is not receiving the intensive home and community-based mental health services he needs to correct or ameliorate his mental health conditions or reduce his behavioral symptoms.

185. L.F.S. has been diagnosed with Attention Deficit/Hyperactivity Disorder, Combined Type, Disruptive Behavior Disorder, Not Otherwise Specified, Mood Disorder, Not Otherwise Specified, Mild Mental Retardation, and possible diagnoses of Bipolar Disorder, Schizophrenia, and Psychosis Not Otherwise Specified. His symptoms include being assaultive, engaging in dangerous behaviors, resisting personal care activities, and significant problems with his sleep.

186. When L.F.S. was four-years-old, soon after he and his family fled to the United States as political refugees from Cuba, he received a psychiatric assessment from his community

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mental health agency which identified his behavioral symptoms as symptoms of a serious mental health condition. At that time, L.F.S.'s mother reported that L.F.S. had a history of being extremely volatile, aggressive, impulsive, and over reactive, and had recently taken a knife and threatened to kill her and himself.

187. L.F.S. began receiving medication management from a community mental health agency and weekly office-based therapy from a second community mental health agency. Years later, in April 2009, L.F.S.'s symptoms were still so unstable that his treating psychiatrist discussed the possibility of hospitalization with his mother. Instead, the family chose to continue attempting to address his needs at home. L.F.S. had a crisis plan which instructed his mother to take him to the emergency room if necessary, but he was never offered any home or community-based crisis intervention or other services.

188. L.F.S.'s therapist requested a neuropsychological assessment on January 21, 2009 to determine whether L.F.S. has Bipolar or psychotic disorders and determine the reason for L.F.S.'s inability to academically progress. When L.F.S.'s mother learned that an appointment was not available through her Medicaid provider for another six months, L.F.S.'s therapist began making requests that the RSN authorize payment for an assessment by an "out-of-network" provider that could see him sooner. The RSN denied the therapist's and L.F.S.'s request, and the neuropsychological evaluation did not occur until October 19, 2009.

189. According to L.F.S.'s treating mental health provider, he needs additional assessments that he has not yet received, including a comprehensive strengths-based assessment that includes home observations of his behaviors and interactions with his family, a Functional Scale and Adaptive Skills assessment, and a sleep study.

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190. Additionally, his mental health provider has recommended Intensive HC-based Services including services delivered by Spanish speaking providers or with qualified Spanish interpreters, therapeutic aid services, home services including a behavior plan and training for L.F.S.'s mother on implementation, mobile crisis intervention and home stabilization services, home family therapy, home individual therapy, and training and support for L.F.S.'s mother from a parent partner. L.F.S. is not receiving any of these services.

191. If L.F.S. does not receive the services and assessments he needs, he will continue to struggle academically and experience conflict at home and school, and he will be at risk of experiencing an increase in his symptoms, hospitalization, and school failure.

192. L.F.S. and his mother never received notice of the availability of Intensive HC-based Services through the Medicaid program, or a notice about his right to request a hearing to dispute denials, reductions, or terminations of his services.

D. Intensive Home and Community-based Mental Health Care Services are Effective and Necessary

193. There is virtual unanimity among mental health experts that children with serious mental health problems require an array of individualized services tailored to meet their needs. Programs implementing such individualized services have been successfully provided to children and have proven more effective and cost efficient than congregate and institutional care.

194. In 2002, the Secretary of DSHS, Dennis Braddock, convened a taskforce of judges, foster care providers, court commissioners, county prosecutors, group home providers, sheriffs, sex offender treatment professionals, high level DSHS administrators and others involved in serving children and families to look at the long term care needs of children with serious mental illness and emotional disturbance. The resultant report, referred to as "The Braddock Report," found that:

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> "Traditionally, community-based interventions have been dismissed as inappropriate on the theory that these youth present too high a risk to self, family safety and community. But to the contrary, wraparound services and multi-systemic treatment that involve the participation of the family, the youth, multiple health, educational, social service and other system partners are proving to be successful in improving the health and well being of youth with severe emotional and behavioral needs, reducing the need for hospitalization and other expensive "crisis" placements."

Select Committee on Adolescents in Need of Long Term Placement, DSHS Washington, *Final Report* (2002).

195. Intensive HC-based Services are also cost effective. For example, compare Medicaid hospitalization rate of $707-1475 (per day) to the cost of Multi-Systemic Therapy at approximately $60 (per day).

196. Intensive home and community-based services encompass a broad and flexible array of services necessary to treat a child's mental health condition at home and in the community in which he or she resides and includes but is not limited to intensive care coordination; mobile services provided on site as necessary to assist a child experiencing a behavioral health crisis; short term crisis stabilization services to prevent or ameliorate a behavioral crisis; skilled staff to provide therapy in the home setting or other natural environment in order to improve the youth's functioning in the those settings and prevent need for an out of home placement; trained mentors available to work with the child in a natural setting to support, coach, and train youth in age-appropriate behaviors, interpersonal communications, problem-solving and conflict resolution; training on independent living, social and communication skills in a natural environment such as skill-building guidance to children and parents (e.g. modeling appropriate behaviors and communication techniques); personal care services for assistance with daily living tasks; and respite care to further stabilize the family home.

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197. Despite this consensus among the State's own mental health professionals that Intensive HC-based Services are necessary, the Defendant has failed to ensure that children receiving treatment through Medicaid funded programs receive the services to which they are entitled by law.

E. The Failure to Provide Intensive HC-based Services Results in Serious and Irreparable Harm

198. Failure to provide intensive home and community-based mental health services results in significant harm including unnecessary and prolonged institutionalization, non-improvement or a decline in mental and physical health, reduced social interaction, academic success and quality of life, a declining family environment and police intervention and confinement within the juvenile justice system.

Unnecessary and Prolonged Institutionalization

199. DSHS has recognized that:

> "The lack of community placement and diversion alternatives contributes to: 1) increasing demand [for institutional beds] on the "front end" [and] 2) protracted or stalled discharge planning on the "back end." In essence the lack of such services results in the "Boarding" of youth who are committed to inpatient treatment on acute community hospital units (e.g., Sacred Heart)."

Issue Statement: Briefing Paper about CLIP Process Kid Team Discussion and Recommendations (April 2007).

200. The average length of a stay in Washington's CLIPs is 297 days, with some populations staying much longer. Children under age 13 average 476 days. A white paper issued in 2006 concluded that the leading cause of discharge delays from CLIPS is the lack of discharge placement and family readiness. *Children's Acute and Non-acute Inpatient Psychiatric and Residential Treatment White Paper* (2006); *See also Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds – Adults and Children,*

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State of Washington DSHS (November 2004) (recommending therapeutic foster care and additional community programming to reduce average length of stay).

201. Beyond the length of stay, over-reliance on restrictive, institutional settings is often harmful to children with mental health problems, placing them in a setting that is antithetical to their successful treatment, in part because removing a child from her parents or a caring adult is, itself, harmful.

202. Moreover, hospitals and restrictive institutions are designed to offer short-term stabilization and behavior management, not intensive, individualized services.

203. The experience of the named Plaintiffs is illustrative and, unfortunately, typical. G.B. was treated on an inpatient basis on five different occasions by the time she was 11; T.F. was institutionalized three times by the time she was 14; T.V. was hospitalized five times over 18 months before being institutionalized for over a year at the state children's psychiatric hospital; S.P. has cycled in and out of the local hospital psychiatric unit five times in the last year and is currently hospitalized due to inadequate community services; P.S. was institutionalized twice at a CLIP facility and hospitalized multiple times; and C.A. is in an inpatient facility due to the lack of community services.

Non-improvement or a Decline in Mental and Physical Health

204. Children who do not receive appropriate treatment cannot get better and are at risk of getting worse. If the decline is severe, many will face the risk of institutionalizations that could continue for years. Children, like T.V., who cannot access recommended intensive services because Defendant's policies and practices deem their symptoms to be not severe enough, must deteriorate to the point they are at risk of hospitalization when their condition will be harder to treat.

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205. The lack of Intensive HC-based Services often also result in physical harm from self harming behaviors (self-burning, cutting or head banging), forced restraint by police or others, fighting due to aggression or confusions, harm due to command hallucinations and other causes. For example, C.A., P.S., and E.H. have cut themselves; P.S. has been injured in physical altercations; and T.F. was almost hit by a car during an episode when she attempted to elope from a treatment facility.

206. Children with mental health symptoms also are at high risk of suicide. Washington State's Department of Health recently released a report acknowledging that on average, two Washington youth commit suicide each week, and that Washington's youth suicide rate is higher than the national average. *See Washington State's Plan for Youth Suicide Prevention 2009.* T.F., P.S., C.A., and E.H. have all had suicidal ideations and have made attempts to take their own lives.

Reduced Social Interactions, Academic Success and Quality of Life

207. The lack of Intensive HC-based Services results in increased risk of school failure and drop out, and a marked decline in the quality of life. S.P. has become so anxious about social interactions that she could attend school only two hours a day. E.D. scores in the 80th percentile for intelligence, but his inability to relate to peers and his condition causes problems in school, at home and in the community. C.A.'s self esteem is bolstered by academic challenge but institutionalized, she has no outlet for her intellectual curiosity, and she has little hope for the future.

208. The symptoms experienced by these children can be barriers to developing positive peer relationships. Furthermore, the cycle of institutionalizations faced by many of these children threatens to foreclose any chance these children have of developing healthy,

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stable, long term relationships on which to build attachments, self-confidence and social skills, leading to a lifetime of challenges with marital, familial and peer relationships, and social isolation.

Declining Family Environment

209. A failure to provide intensive home and community-based mental health services is disruptive to the family and often results in out of home placements, involuntary foster care and occasionally homelessness, eviction, or transfers among family members struggling to provide appropriate care. T.R., S.P., C.A. and T.F. are all currently in long-term out-of-home placements. P.S., T.V. and G.B. have experienced long-term displacement and are at risk of future institutionalization. P.S. and his family were forced to move to avoid eviction due to his mental health crises. Those that remain at home struggle on a day-to-day basis with their families living in fear of harm to their other children, themselves and others family members and friends.

Police Intervention and Confinement within the Juvenile Justice System

210. Many children with mental health needs are arrested, detained, and taken into custody by Washington's Juvenile Rehabilitation Administration (JRA). The State of Washington has found that 62% of children enter the custody of JRA with unmet mental health needs.

211. Confinement within a juvenile detention facility and police intervention is not a substitute for Intensive HC-based Services. Physical restraint frequently exacerbates these children's symptoms, treatment is frequently unavailable and these children are torn from their families. Yet this is a tool frequently used in place of Intensive HC-based Services, particularly mobile crisis care. For example, T.F. was placed in a facility in Idaho which used police intervention in response to her mental health crises, was arrested while in the facility eight times

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during her first four months of treatment, and spent the vast majority of the past six months in juvenile criminal detention. At only 11-years-old, T.V. has been arrested and detained on multiple occasions. P.S., T.F., T.R. and E.D.'s only crisis plan was to call "9-1-1" for police intervention. P.S. has Post Traumatic Stress Disorder and arrest by the police further traumatizes him and exacerbates his condition. P.S. has requested a crisis plan and mobile crisis services to avoid relying on the police, but the Defendant has failed to provide coverage for this necessary service.

212. As one recent report stated:

> "The concept of prevention – prevention of failure in school, job loss, homelessness, criminal behavior and untold suffering – seems hardly to exist within the public mental health system."

Children's Mental Health in Washington State: A Public Health Perspective Needs Assessment, Washington Department of Health (November 2007). In order to protect Washington's Medicaid children and prevent further harm, Defendant must be compelled to comply with its legal obligations.

VII. REQUISITES FOR RELIEF

213. By reason of the factual allegations set forth above, an actual controversy has arisen and now exists between Plaintiffs and the Defendant. Plaintiffs contend that their rights under the Constitution and laws of the United States are being violated, while the Defendant is charged with enforcing and complying with those legal requirements. A declaration from this Court that Plaintiffs' rights have been violated is therefore necessary and appropriate.

214. Defendant's failure to comply with the requirements of federal and state law will result in irreparable harm to Plaintiffs. Plaintiffs have no plain, adequate, or complete remedy at

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law to address the wrongs described herein. Plaintiffs therefore seek injunctive relief restraining Defendant from engaging in the unlawful and unconstitutional acts and policies described herein.

VIII. CLAIMS FOR RELIEF

COUNT I
Violations of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provisions of the Medicaid Act

215. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

216. Defendant has failed to establish policies, procedures, and practices to ensure Plaintiffs and members of the Plaintiff class receive adequate notice of the specific behavioral and mental health treatment services available under the EPSDT provisions of the federal Medicaid Act, including intensive, community and home-based mental health services, which has the effect of denying these services to children with physical or mental illnesses or conditions, in violation of 42 U.S.C. § 1396a(a)(43)(A).

217. Defendant has failed to provide or otherwise arrange for Plaintiffs and the members of the Plaintiff class to receive the EPSDT early and periodic screening and diagnostic services that would otherwise determine the existence of any physical or mental illnesses or conditions, in violation of 42 U.S.C. §§ 1396a(a)(10)(A), 1396(a)(43)(B), 1396d(a)(4)(B), and 1396d(r)(1)(A).

218. Defendant has failed to provide or otherwise arrange for Plaintiffs and the members of the Plaintiff class to receive the necessary behavior and mental health services, including intensive, community and home-based mental health services, that would treat or ameliorate their physical or mental illnesses or conditions, in violation of 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), and 1396d(r)(5).

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219. Defendant's actions and omissions described above violate 42 U.S.C. § 1983 by depriving Plaintiffs and the members of the Plaintiff class of their statutory rights under the EPSDT provisions of the federal Medicaid Act to receive necessary screening, diagnostic, and treatment services and to receive notice of the availability of these services.

COUNT II
Violation of the Comparability Provisions of the Federal Medicaid Act

220. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

221. The "comparability" requirement of the Medicaid Act requires that all categorically needy individuals with comparable needs receive comparable Medicaid funded services. 42 U.S.C. § 1396a(a)(10)(B). The State violates the "comparability" requirement if it reduces, denies, or terminates a Medicaid funded service for an individual for a reason other than the individual's needs consistent with 42 U.S.C. § 1396a(a)(30)(A).

222. The Defendant has failed to establish or maintain policies, procedures, or practices that will prohibit reductions, terminations, or denials of medically necessary intensive in home and community-based mental health services to children and youth on the bases of their diagnoses, geographic location, and qualifications for child welfare DCFS services, in violation of 42 U.S.C. § 1396a(a)(10)(B), which is enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983.

COUNT III
Violation of the Due Process Provisions of the Federal Medicaid Act

223. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

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224. The Medicaid Act requires that participating states provide an opportunity for a fair hearing for any individual whose request for Medicaid services have been denied or provided with reasonable promptness. 42 U.S.C. § 1396a(a)(3).

225. Defendant has failed to establish and maintain customs, policies, and practices to provide Plaintiffs and members of the Plaintiff class with adequate written notice of reductions, terminations, and denials of Medicaid funded intensive home and community-based services and their rights to a pre-termination or reduction fair hearing, in violation of 42 U.S.C. § 1396a(a)(3), which is enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983.

COUNT IV
Violation of the Due Process Provision of the Fourteenth Amendment of the United States Constitution

226. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

227. The Due Process Clause of the United States Constitution establishes the right for Plaintiffs and members of the Plaintiff class to receive adequate notice of reductions, terminations, and denials of Medicaid funded services and their right to a fair hearing to challenge such actions prior to implementation. *See Goldberg v. Kelly*, 397 U.S. 254 (1970); 42 U.S.C. § 1396a(a)(3).

228. Defendant has failed to establish and maintain customs, policies, and practices to provide Plaintiffs and members of the Plaintiff class with adequate written notice of reductions, terminations, and denials of Medicaid funded intensive home and community-based services and their rights to a pre-termination or reduction fair hearing in violation of the Due Process clause of the Fourteenth Amendment of the Constitution, which is enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983.

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COUNT V
Violation of Americans with Disabilities Act and Section 504 of the Rehabilitation Act

229. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

230. Plaintiffs and members of the Plaintiff class have behavioral, emotional, and psychiatric impairments that qualify them as individuals with disabilities within the meaning of the ADA, 42 U.S.C. § 12131(2), and are "otherwise qualified individuals with a disability" within the meaning of the Rehabilitation Act, 29 U.S.C. § 794.

231. Defendant is a public official of a public entity subject to the provisions of the ADA. 42 U.S.C. § 12131(1)(A). Defendant's agency receives federal financial assistance, and Defendant is thus subject to the provisions of the Rehabilitation Act.

232. Defendant has failed to administer services, programs, and activities in the most integrated setting appropriate to the needs of children who need intensive mental health services in violation of the ADA and Rehabilitation Act.

233. Defendant has discriminated against Plaintiffs and members of the Plaintiff class on the basis of their disabilities by failing to make reasonable modifications in their policies, practices, or procedures. Reasonable modification of Defendant's policies, practices, or procedures would not fundamentally alter the nature of their services, programs, or activities, but rather would further Defendant's stated goals. 28 C.F.R. § 35.130(b)(7).

234. Defendant has discriminated against Plaintiffs and members of the Plaintiff class solely on the basis of disability in violation of the Rehabilitation Act and ADA by: (i) failing to provide reasonable accommodations to allow Plaintiffs and members of the Plaintiff class to participate fully in Defendant's programs and receive adequate services; and (ii) failing to provide and support appropriate community-based placements, instead requiring Plaintiffs and

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315 5th Avenue South, Suite 850
Seattle, Washington 98104
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members of the Plaintiff class to be confined in restrictive, institutional settings in order to access necessary mental health services.

235. Defendant's acts and omissions alleged herein have denied and continue to deny Plaintiffs and members of the Plaintiff class the opportunity to benefit from Defendant's services, programs, and activities.

IX. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Assume jurisdiction over this action and maintain continuing jurisdiction until Defendant is in full compliance with every order of this Court;

B. Certify that Plaintiffs may maintain this action as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure and appoint the individual named Plaintiffs as Class representatives;

C. Declare that Defendant's policies, practices, acts, and omissions violate the EPSDT and Comparability provisions of the Medicaid Act, which requires the Defendant to provide for necessary intensive in-home and community-based mental health services;

D. Declare that Defendant's policies, practices, acts, and omissions violate the due process provision of the Medicaid Act and the Due Process Clause of the Fourteenth Amendment to the United States Constitution, which require the Defendant to provide notice to the Plaintiffs and members of the Plaintiff class informing them of their rights when a Medicaid service is terminated, suspended, reduced or denied and providing them with a pre-termination opportunity to appeal such action;

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E. Declare that Defendant's policies, practices, acts, and omissions violate the Plaintiffs' rights to receive mental health services in the most integrated setting appropriate to their needs under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act;

F. Grant a preliminary and permanent injunction requiring the Defendant to:

a. establish and implement policies, procedures, and practices to screen and assess members of the Plaintiff class for unmet mental health needs, including intensive home and community-based services, to ensure that class members are reliably identified and adequately served;

b. conduct professionally-adequate assessments of all Plaintiffs and members of the Plaintiff class who reside in private or public mental health facilities to determine whether intensive home and community-based mental health services are necessary to treat or ameliorate their behavioral, emotional, or psychiatric conditions;

c. conduct professionally-adequate assessments of all Plaintiffs and members of the Plaintiff class who reside in private or public mental health facilities, and to determine whether or not such children are receiving mental health services in the most integrated setting appropriate to their individual needs.

d. provide meaningful notice to Medicaid-eligible children and their families of the availability of the full range of Medicaid-funded mental health, and behavioral services available under EPSDT program, including intensive home and community-based services;

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315 5th Avenue South, Suite 850
Seattle, Washington 98104
(206) 324-1521 · Fax: (206) 957-0729

e. establish and implement policies, procedures, and practices that are sufficient to ensure that the Plaintiffs and all members of the Plaintiff class promptly receive coverage of necessary, intensive home and community-based mental health services, including professionally-adequate assessments, crisis and case management services;

f. establish and implement policies, procedures, practices, and reimbursement rates to ensure that sufficient qualified providers are available to offer intensive home and community-based mental health services, including professionally-adequate assessments, crisis, and case management services throughout the state and in a culturally appropriate manner;

g. remove any barriers or criteria which prevent Medicaid-eligible children from applying for and accessing necessary EPSDT mental health services, including intensive home and community-based mental health services;

h. promptly provide intensive home and community-based mental health services to all Plaintiffs who would benefit from them;

G. Award to the Plaintiffs the reasonable costs and expenses incurred in the prosecution of this action, including but not limited to reasonable attorneys' fees and costs; and

H. Award such other equitable and further relief as the Court deems just and proper.

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Disability Rights Washington
315 5th Avenue South, Suite 850
Seattle, Washington 98104
(206) 324-1521 · Fax: (206) 957-0729

DATED this 24th day of November, 2009.

/s/Regan Bailey
Regan Bailey, WSBA No. 39142
reganb@dr-wa.org
Susan Kas, WSBA No. 36592
susank@dr-wa.org
DISABILITY RIGHTS WASHINGTON
315 5th Avenue South, Suite 850
Seattle, WA 98104
Telephone: (206) 324-1521
Facsimile: (206) 957-0729

/s/Susan E. Foster
Susan E. Foster, WSBA No. 18030
SFoster@perkinscoie.com
Frederick B. Rivera, WSBA No. 23008
FRivera@perkinscoie.com
Travis A. Exstrom, WSBA No. 39309
TExstrom@perkinscoie.com
PERKINS COIE LLP
1201 Third Avenue, Suite 4800
Seattle, WA 98101-3099
Telephone: (206) 359.8000
Facsimile: (206) 359.9000

/s/Jane Perkins
Jane Perkins, SBN 104784
perkins@healthlaw.org
NATIONAL HEALTH LAW PROGRAM
211 N. Columbia Street
Chapel Hill, NC 27514
Telephone: (919) 968-6308

/s/Patrick Gardner
Patrick Gardner, CB No. 208199
pgardner@youthlaw.org
Fiza Quraishi, CB No. 252033
fquraishi@youthlaw.org
NATIONAL CENTER FOR YOUTH LAW
405 14th Street, 15th Floor
Oakland, CA 94612
(510) 835-8098

Attorneys for Plaintiffs