

**IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA**

FREDERICK L., ET AL.,	:	
Plaintiffs,	:	CIVIL ACTION
	:	
v.	:	
	:	
DEPARTMENT OF PUBLIC	:	
WELFARE, ET AL.,	:	
Defendants.	:	No. 00-4510

MEMORANDUM AND ORDER

Schiller, J.

September 1, 2004

Plaintiffs are mental health patients institutionalized at Norristown State Hospital (“NSH”). Plaintiffs brought this class action against the Department of Public Welfare of the Commonwealth of Pennsylvania (“DPW”) and Feather O. Houstoun,¹ in her official capacity as the Commonwealth’s Secretary of Public Welfare, seeking declaratory and injunctive relief for alleged violations of their federal statutory rights to a more accelerated program of deinstitutionalization. Following a three-day bench trial in May 2002, this Court found in favor of Defendants, holding that, under *Olmstead v. L.C.*, 527 U.S. 581 (1999), Plaintiffs were not entitled to their requested relief because it would have required a “fundamental alteration” of the Commonwealth’s programming and budgetary allocations. *Frederick L. v. Dep’t of Pub. Welfare*, 217 F. Supp. 2d 581 (E.D. Pa. 2002). Plaintiffs subsequently appealed. On April 13, 2004, the United States Court of Appeals for the Third Circuit vacated this Court’s judgment and remanded for further evaluation of the Commonwealth’s fundamental alteration defense according to the standards enunciated in *Olmstead. Frederick L. v. Dep’t of Pub. Welfare*, 364 F.3d 487 (3d. Cir. 2004). Specifically, the Third Circuit found that this

¹ Estelle B. Richman is the current Secretary of Public Welfare.

Court had failed hold the Commonwealth to *Olmstead*'s requirement of a plan for future deinstitutionalization. By Order of May 10, 2004, this Court directed Defendants to submit briefing in accordance with the Third Circuit opinion.

This case illustrates the difficulties accompanying judicial involvement in a state's complex mental health system. Fortunately, all parties involved in this action are pursuing common goals, which has not been the case in other litigation facing similar questions. *See Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d 487, 500 (3d. Cir. 2004) (noting, inter alia, school desegregation litigation). Nonetheless, despite the parties' general agreement upon an ultimate destination, there is considerable dispute over what path to take and how fast to travel. It is this dispute which this Court must address.

I. BACKGROUND

This Court's factual findings, which the Third Circuit found were fully supported by the evidence in the record, *Frederick L.*, 364 F.3d at 500, are set out in this Court's Memorandum and Order dated September 5, 2002 and incorporated by reference herein. *Frederick L.*, 217 F. Supp. 2d at 582-90. The following additional facts, presented in the parties' post-remand submissions, are relevant to the issue presently before this Court.

DPW, an agency of the Commonwealth of Pennsylvania ("Commonwealth"), is responsible for, inter alia, a variety of programs aimed at providing publicly funded mental health care to residents of the Commonwealth. *Id.* at 582. Within DPW, the Office of Mental Health and Substance Abuse Services ("OMHSAS") is directly responsible for the provision of mental health services. *Id.* OMHSAS utilizes a multi-faceted planning process to determine needs and allocate

resources to the various counties throughout the Commonwealth. (Richman Decl. ¶ 8.) As part of that process, a statewide task force was convened in February 2000 to address the future of the Commonwealth’s mental health delivery system. (Erney Decl. ¶ 5.) In February 2002, OMHSAS issued a Community/Hospital Integration Plan (“Integration Plan”) that reflected the work of the statewide task force. (Erney Decl. ¶ 5; Richman Decl. ¶ 13.)

A. Community/Hospital Integration Plan

The Integration Plan is a statewide planning document that sets general goals and “provides the broad parameters for future actions” in the provision of mental health services in the Commonwealth. (Defs.’ Post-Remand Submission Ex. 1 at 19.) The clear emphasis of the statewide plan is to move toward further deinstitutionalization of mental health services.² (*Id.* at 20 (“OMHSAS is committed to continuing . . . to reinforce treatment and support options in the most integrated setting.”).) The overarching goals of the plan are defined as follows:

1. Support the development of a comprehensive array of treatment, rehabilitation and support services that promote clinically appropriate, least restrictive, least intrusive approaches appropriate to the needs of mental health consumers, including educational, vocational, residential, spiritual, and social needs.
2. Maintain commitment to re-orienting the focus of the mental health system away from reliance on large institutions to community care, including utilizing up to 250

² At the time the Integration Plan was issued a similar planning initiative was already underway in the southeast region service area, which includes NSH. In Fiscal Year 2001-02, the southeast region submitted its Southeast Regional Mental Health Plan (“SERP”) to OMHSAS, which included a proposal to move sixty individuals from NSH to community placements and to fund the development of a regional coordinator’s office. (Erney Decl. ¶ 7; Defs.’ Post-Remand Submission Ex. 7A at 2.) The SERP was funded by the Commonwealth and implemented successfully. (Erney Decl. at ¶ 9; Defs.’ Post-Remand Submission Ex. 7A at 2.) The Integration Plan focuses on undertaking similar efforts in the other service areas. (Erney Decl. ¶ 7.)

Community/Hospital Integration Projects Program³ (“CHIPP”) beds per year as a vehicle for decreasing use of state hospitals.

3. Build a mental health system for adults founded on the principles of the community support program, embrace recovery principles, reflect cultural competency, and meet the needs of any identified special populations.
4. Assure that continuous quality improvement measures play a significant role in the development and delivery of all mental health treatment, services and supports.
5. Base the community system on a strong fiscal foundation which maximizes current resources.

(*Id.* at 15-18; Richman Decl. ¶ 13.) According to the Integration Plan, these overarching goals are best implemented through regional planning groups, which have access to data that is specific to local service needs. (Defs.’ Post-Remand Submission Ex. 1 at 19-20.)

B. Service Area Planning Groups

As the mechanism for implementing the 2002 Integration Plan, OMHSAS created nine Service Area Planning groups (“SAPs”) consisting of the geographic service areas of each of the nine state-operated hospitals. (Erney Decl. ¶ 10.) The Integration Plan requested that each regional planning group submit five-year plans to implement DPW’s goals beginning in Fiscal Year (“FY”) 2005-06. (Defs.’ Post-Remand Submission Ex. 1 at 21; Erney Decl. ¶ 11.) Specifically, each SAP was directed to prepare a formal written plan assessing the needs of its population in order to

³ CHIPP was initiated in 1991-92 to support the discharge of persons with long-term histories of hospitalization and complex service needs that could not be met in existing community programs. (Defs.’ Post-Remand Submission Ex. 1 at 4; Erney Decl. ¶ 25.) Through CHIPP, state hospital funds are diverted to county mental health programs to develop new community services in exchange for closing access to the beds vacated by discharged patients. (Erney Decl. ¶ 25.) In the Integration Plan, then-Secretary of DPW Feather Houstoun recognized the fiscal challenges to meeting the 250-bed goal and noted the need for planning efforts to consider resources beyond CHIPP funds. (Defs.’ Post-Remand Submission Ex. 1 at 5; Erney Decl. ¶ 8.)

progress toward three system goals within the next five years: (1) “no person will be hospitalized in a state hospital beyond two years”; (2) “no person will be involuntarily committed to a community hospital more than twice in one year”; and (3) “the incarceration of the target population will be reduced, with the intent being to provide treatment in lieu of jail for those persons with mental illness who touch the criminal justice system.” (Erney Decl. ¶¶ 11-12.) The regional groups were instructed to include proposals not only for community programs for persons currently institutionalized, but also for the infrastructure development necessary to avoid institutional placement of mental health patients in the first instance. (Defs.’ Post-Remand Submission Ex. 4 at 4-5 (Service Area Planning Guidelines), Ex. 1 at 5 (“The charge to the planning groups, therefore, is to design a comprehensive mental health system that optimizes the opportunity for treatment in the most integrated settings appropriate by providing a balanced mix of services.”).) In pursuit of these goals, the Integration Plan encouraged regional planning groups to consider both CHIPP funds as well as additional potential resources to support new development of community options beyond CHIPP. (*Id.* Ex. 1 at 5, 21; Erney Decl. ¶ 8.) The regional planning groups were also directed to provide recommendations regarding the future role of institutional settings given OMHSAS’s ongoing commitment to integration. (Defs.’ Post-Remand Submission Ex. 1 at 20.)

To assist in the planning process, OMHSAS provided each planning body with planning guidelines, a plan template, county-specific constituent and service system data, county census data, hospital census and budget data, and service area planning goals. (Erney Decl. ¶ 14; Defs.’ Post-Remand Submission Ex. 4.) The planning guidelines set out the purpose of the planning bodies as follows: to “describe the service area and County strategy to ‘shift the mental health service delivery system away from reliance on large institutions and towards an array of treatment services and

supports in all communities throughout the Commonwealth.” (Defs.’ Post-Remand Submission Ex. 4 at 2.) All nine of the first-year SAP plans, which were due by May 30, 2004, have been received by OMHSAS. (Erney Decl. ¶ 16; *see also* Defs.’ Post-Remand Submission Exs. 7A, 7B (examples of submitted plans).) OMHSAS has committed to “use the plans submitted by each county/region to develop its annual budget request to the Department.” (Defs.’ Post-Remand Submission Ex. 1 at 21; *see also* Erney Decl. ¶ 21.)

C. County-Level Planning

In addition to the SAP process, the counties also participate in providing community-based mental health services.⁴ Each year, each county submits a plan and expenditure estimate to OMHSAS. (Erney Decl. ¶ 17.) In past years, the county plans were submitted too late to be incorporated into OMHSAS’s annual budget request to DPW. (*Id.* ¶ 18.) In 2003, however, OMHSAS revised the submission deadlines so that OMHSAS could effectively take county plans into account. (*Id.*) The FY 2005-06 plans, submitted as of May 30, 2004, were the first to incorporate this new timeline. (*Id.* ¶¶ 19-20.) The Deputy Secretary of OMHSAS, Joan Erney, stated that “OMHSAS has made a commitment to review and give feedback to the counties and the service area stakeholder groups that developed the plans, and to use the plans to develop both future budget requests and a statewide strategy for providing mental health services.” (*Id.* ¶ 21.)

D. Deinstitutionalization Trends: Past and Future

Defendants have provided data outlining deinstitutionalization trends and demonstrating

⁴ Pursuant to the 1966 Mental Health and Mental Retardation Act, the counties are responsible for providing community-based mental health and mental retardation services. *See* 50 PA. CONS. STAT. ANN. § 4301 (West 2001). The Commonwealth has statutory responsibility to fund county-administered services through a grant-allocation process. (Erney Decl. ¶ 17.)

declines in hospital admissions and length of stay. (Erney Decl. ¶¶ 23-26, 28-29; Richman Decl. ¶ 6.) From FY 2000-01 through FY 2003-04, the civil population of DPW's nine state hospitals decreased by 14%. (Erney Decl. ¶¶ 23, 26 (noting that during FY 2002-03, there were 2,203 CHIPP discharges from state hospitals, with \$164,409,141.00 redirected to county programs).) Furthermore, of the 410 individuals identified as class members as of December 9, 2001, 54.3% had been discharged from NSH by May 2004.⁵ (*Id.* ¶ 29.) This progress has been accomplished in part through creative funding solutions. For instance, OMHSAS collaborated with the Office of Mental Retardation in FY 2002-03 to jointly fund seven discharges into community settings. (*Id.* ¶ 27.)

Importantly, DPW officials have emphasized OMHSAS's commitment to continue this progress. (Richman Decl. ¶ 12 ("There will be no reversal of the Department's proven commitment to deinstitutionalization throughout our state hospital system."); Erney Decl. ¶ 38 ("I can state unequivocally we will continue our commitment to building a community mental health system that provides people with opportunities for growth, recovery, and inclusion.")) Joan Erney, Deputy Secretary of OMHSAS, stated that, over the course of the five year planning cycle and within the limits of available funding, OMHSAS is committed to help people who have been hospitalized over two years to move to community settings.⁶ (Erney Decl. ¶ 22.) To that end, OMHSAS intends to: (1) continue the annual CHIPP initiative; ⁷ (2) continue an annual consideration of all state

⁵ An additional 6.83% had died. (Erney Decl. ¶ 29.)

⁶ 54% of the system's current population have been hospitalized for over two years. (Erney Decl. ¶ 22.)

⁷ Ms. Erney stated that, in FY 2004-05, OMHSAS anticipates another initiative of up to fifty-three hospital discharges. In a subsequent submission, DPW confirmed that the Governor requested funding for the upcoming Fiscal Year for only thirty-three CHIPP discharges, but that DPW "is anticipating the opportunity to implement up to fifty-three discharges by accelerating,

psychiatric hospitals for consolidation or closing; (3) continue to reinforce identification and use of alternative funding options that will maximize resources and build community treatment and service options; and (4) continue partnering with counties to develop strong community resources. (*Id.*)

Defendants also note that increases in alternative community services have allowed more people to be diverted from hospital placement. Specifically, Defendants note the strong performance of the HealthChoices Behavioral Health Program, which provides alternative forms of community mental health services in twenty-five counties (*id.* ¶¶ 30-31), the upcoming creation of five additional Local Housing Option Teams, which provide housing options for people with disabilities (*id.* ¶ 35), and the expansion of the Projects to Assist in Transition from Homelessness grants, which fund projects to reduce homelessness for people with mental illness (*id.* ¶ 37). Expansion of these and other alternative services reduces the need for institutionalization. (*Id.* ¶ 32.)

II. DISCUSSION

In *Olmstead v. L.C.*, the Supreme Court held that unnecessary institutionalization of mental health patients may constitute discrimination in violation of the ADA’s integration mandate. *Olmstead*, 527 U.S. at 597. However, the *Olmstead* plurality made equally clear that “[t]he State’s responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless.” *Id.* at 602. Cognizant of states’ responsibility to provide a range of services to a diverse population, the reality of budgetary constraints, and the difficulties accompanying judicial involvement in political processes, the Supreme Court noted that a state may defend against such

to the extent possible, the [Southeast Region SAP] for FY 2004-05.” (Defs.’ Statement Correcting and Clarifying Post-Remand Submission ¶ 2.)

claims by demonstrating that the requested relief would require a “fundamental alteration” of the state’s mental health system. *Id.* at 604-06; *Frederick L.*, 364 F.3d at 498 (“[T]he judiciary is not well-suited to superintend the internal budgetary decisions of DPW.”); *see also Olmstead*, 527 U.S. at 612-13 (Kennedy, J., concurring) (“Grave constitutional concerns are raised when a federal court is given the authority to review the State’s choices in basic matters such as establishing or declining to establish new programs.”). In the instant case, this Court found that the Commonwealth had successfully established the fundamental alteration defense. On appeal, the Third Circuit concluded that this Court’s factual findings were fully supported by the evidence in the record. *Frederick L.*, 364 F.3d at 500. The Third Circuit also found that most of this Court’s legal conclusions were consistent with the governing legal principles. *Id.* The Third Circuit vacated this Court’s decision and remanded, however, based on its reading of the “comprehensive plan” referred to in *Olmstead*.

Under *Olmstead*, a state is entitled to the fundamental alteration defense if it can demonstrate that “in the allocation of available resources, immediate relief would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population.” *Olmstead*, 527 U.S. at 604. The *Olmstead* plurality set forth the following hypothetical when describing the circumstances under which a state may resist modifications that entail a fundamental alteration of the states’ services and programs:

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 605-06. Citing this passage, the Third Circuit held that the presence of a plan indicating a commitment to future progress toward deinstitutionalization is an essential prerequisite of the

fundamental alteration defense and remanded for consideration of whether such a plan is present in this case. *Frederick L.*, 364 F.3d at 500. Thus, two issues are presently before this Court: (1) what are the substantive requirements of the plan referred to in *Olmstead*; and (2) whether the Commonwealth's post-remand submission satisfies those requirements.

A. Requirements of a Plan

The Third Circuit opinion does not elucidate the specific requirements of the *Olmstead* plan, but rather provides general guidance. The heart of the plan requirement is described as follows:

The issue is not whether there is a piece of paper that reflects that there will be ongoing progress toward community placement, but whether the Commonwealth has given assurance that there will be. In that connection what is needed at the very least is a plan that is communicated in some manner. The District Court accepted the Commonwealth's reliance on past progress without requiring a commitment by it to take all reasonable steps to continue that progress. Under the circumstances presented here, our reading of *Olmstead* would require no less.

Id. The Third Circuit opinion defined the outer bounds of the planning requirement more concretely. To that end, the Court noted that the ongoing review procedures at NSH, in which DPW conducts monthly reviews of patients to determine when they are prepared for discharge, "falls far short of the type of plan that we believe the Court referred to in *Olmstead*." At the other end of the spectrum, however, the Court stated that it would be "inappropriate for us to direct DPW to develop 60 community residential slots per year." *Id.* The Third Circuit concluded its discussion of the plan requirement by noting that "[DPW] must be prepared to make a commitment to action in a manner for which it can be held accountable by the courts." *Id.*

The Third Circuit also cited two decisions approvingly for "giv[ing] considerable weight to the presence of a planning and/or waiting list referred to by the *Olmstead* plurality as examples of factors to be considered in connection with the fundamental-alteration defense." *Id.* at 498 (*citing*

Makin v. Hawaii, 114 F. Supp. 2d 1017 (D. Haw. 1999) & *Williams v. Wasserman*, 164 F. Supp. 2d 591 (D. Md. 2001).) These decisions, however, fail to provide much useful guidance for the substance of the plan requirement. In *Makin*, the district court denied the defendant’s motion for summary judgment because it found that the defendants “provided no evidence of any . . . plan” and because disputes of material fact precluded summary judgment on the fundamental alteration defense. *Makin v. Hawaii*, 114 F. Supp. 2d at 1035. Due to the procedural posture of the case and the fact that the court was not presented with a plan to analyze, the *Makin* decision does not provide much guidance to this Court.⁸ In *Williams*, the district court states that the plan referred to by the *Olmstead* plurality is not a separate requirement of the fundamental alteration defense:

As I see it, this example was intended to clarify the standards explained by the plurality and does not provide the basis for a separate substantive argument. In any event, the State has established a waiting list, a waiting list equity fund, and prioritized categories of crisis resolution for providing services. There is no indication that the failure to move people off the waiting list results from an endeavor to keep the State's institutions fully populated.

164 F. Supp. 2d at 633 n.37 (internal citations omitted). Although the district court addresses the plan nonetheless, the brief treatment, located within a footnote, does not provide much assistance regarding the contours of the plan requirement.

In sum, this Court concludes that while Defendants’ plan need not be a formal document, it must at least consist of (1) an “assurance” or “commitment” to “take all reasonable steps” so that there will be “ongoing progress” toward community placement in the future; (2) the commitment

⁸ Notably, however, *Makin* read *Olmstead* as holding that a state could establish the fundamental alteration defense “if the State could prove that it was *developing* a ‘comprehensive plan’ to keep the wait list ‘moving at a reasonable pace.’” *Makin*, 114 F. Supp. 2d at 1035 (emphasis added). Thus, according to the *Makin* court, a state may satisfy the fundamental alteration defense before a plan is actually in place or being implemented.

must be “communicated in some manner”; and (3) DPW must be “held accountable.”

B. Analysis of Defendants’ Submission

Before the Third Circuit, Plaintiffs were joined by *Amici*,⁹ who described the plan requirement as follows:

The emphasis on a comprehensive plan indicates that the Supreme Court intended to shield States that had focused on and planned for the need to place people into the community on a statewide basis, prior to and apart from the litigation before the Court. A comprehensive plan is more than an annual inquiry into whether there are extra funds left over in the budget to fund creation of community beds. It is long-term and central to the State’s mental health policy, not an “add-on” or “extra funding” item subject to elimination at the first chill of budget difficulties.

Frederick L., 364 F.3d at 499 (quoting *Amici*’s Br. at 23). Defendants’ submission falls squarely within *Amici*’s able description of the plan requirement. As previously described, *see supra* Part I, Defendants have submitted detailed accounts and evidence regarding the complex and comprehensive statewide planning process. This process begins by analyzing regional needs and identifying opportunities for the provision of community-based services. The regional and county plans are then transmitted to OMHSAS to be considered and incorporated into the statewide budgetary process. This process is designed to enable the efficient allocation of available resources to serve the needs of the diverse mental health population.

Both the planning documents and statements of DPW officials convince this Court that deinstitutionalization is a central and long-term goal of mental health service provision in the Commonwealth and will continue to be so in the future. Furthermore, the goal of increased community placement is evidenced in the directives given to the planning bodies, and in the

⁹ The *Amici* brief was filed by Robert D. Fleischner of the Center for Public Representation on behalf of fourteen former state mental health commissioners, directors and administrators.

proposed plans created through that process. Although funding constraints certainly limit the pace of progress, the Integration Plan and the SAP plans reflect efforts to identify additional alternative means of increasing community-based services in the pursuit of decreasing the system's reliance on institutionalization.

Plaintiffs argue that Defendants' submission falls short of *Olmstead*'s requirements because Defendants have not provided a "concrete plan" with "measurable outcomes" and a "timeline for the discharge of unnecessarily institutionalized class members." (Pl.'s Resp. at 10.) Furthermore, Plaintiffs note that DPW has not yet approved the regional plans and has not committed to requesting full funding for their implementation. (*Id.* at 9.) Finally, Plaintiffs submit that the following proposed order is necessary to bring DPW into compliance with the Third Circuit's ruling: (1) DPW will make some portion of the FY 2004-05 funding initiative to discharge state hospital residents available to class members; (2) DPW will seek funding for the five-year initiative proposed in the Southeast Region Mental Health Strategic Area Plan to allow the discharge of twenty NSH residents per year for five years beginning no later than FY 2005-06; (3) DPW will assure implementation of that initiative if funding is received or, if full funding is not received, will assure implementation to the extent funding is available; and (4) this Court will retain jurisdiction for purposes of enforcement. (*Id.* at 2-3.)

This Court reads neither *Olmstead* nor the Third Circuit's ruling to require the specific commitments Plaintiffs seek. If a concrete plan with such requirements were required, the Third Circuit would certainly have said as much. Instead, the imprecision of the plan requirements in the Third Circuit opinion reflect that Court's acknowledgment that the fundamental alteration defense was designed to protect state processes like those described herein. The *Olmstead* plurality was

careful to protect states' ability to distribute services equitably and manage mental health programs in general. Moreover, the Third Circuit recognized that the Supreme Court "did not envision the fundamental-alteration defense to be a rare one that states would seldom be able to invoke." *Frederick L.*, 364 F.3d at 493 (citing *Olmstead*, 527 U.S. at 603). This Court therefore concludes that the level of micromanagement Plaintiffs seek would be inappropriate. Moreover, although Defendants have committed to using the SAPs and county plans to develop future budget requests (Erney Decl. ¶ 21), they cannot commit to seek full funding for these plans as Plaintiffs request. The Third Circuit noted that the complexities of the budget process limit DPW's discretion in funding requests. *Frederick L.*, 364 F.3d at 497-98 (stating that DPW's pre-budgetary process is "beyond judicial scrutiny" and that "the judiciary is not well-suited to superintend the internal budgetary decisions of DPW"). Finally, Plaintiffs' request that this Court order a specific commitment of resources to the class members runs counter to *Olmstead*'s requirement that states must be permitted to consider the needs of all mentally ill people served by the state. *Frederick L.*, 364 F.3d at 494 ("Olmstead explains that the ADA does not compel states to provide relief where the requested relief would require the state to neglect the needs of other segments of the mentally disabled population who are not litigants before the court.")

III. CONCLUSION

In conclusion, the Court finds that the submitted plans and DPW's planning process deserve the protection of the fundamental alteration defense. DPW's process takes a comprehensive, holistic, and forward-looking approach to the provision of a full range of mental health services, with an emphasis on not only discharging current hospitalized patients, but also seeking to avoid

hospitalization in the first place. While the Third Circuit is correct that we cannot assume that “past actions auger future commitments,” 364 F.3d at 501, the evidence presented amply demonstrates DPW’s central and long-term commitment that all reasonable steps will be taken to continue the past progress noted in the Third Circuit’s opinion. *Id.* at 499-501 (noting Commonwealth’s past progress and *Williams*’ court’s heavy reliance on Maryland’s past history of deinstitutionalization). An appropriate Order follows.

**IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA**

FREDERICK L., ET AL.,	:	
Plaintiffs,	:	CIVIL ACTION
	:	
v.	:	
	:	
DEPARTMENT OF PUBLIC	:	
WELFARE, ET AL.,	:	
Defendants.	:	No. 00-4510

ORDER

AND NOW, this 1st day of **September, 2004**, upon consideration of the Third Circuit's opinion in *Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d 487 (3d. Cir. 2004), Defendants' Post-Remand Submission, Plaintiffs' response thereto, Defendants' reply thereon, and for the foregoing reasons, it is hereby **ORDERED** that:

1. Judgment is entered in favor of Defendants and against Plaintiffs and the Plaintiff class.
2. The Clerk of Court is directed to close this case.

BY THE COURT:

Berle M. Schiller, J.