ORIGINAL

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAII

UNITED STATES OF AMERICA, Plaintiff, vs. STATE OF HAWAI'I, et. al., Defendants.	CIVIL NO. 91-00137 DAE-KSC TWELFTH REPORT AND RECOMMENDATION; EXHIBITS "A" - "C"

TWELFTH REPORT AND RECOMMENDATION

This Twelfth Report and Recommendation discusses the seventh and final visit of the Special Master's Community Mental Health Services Evaluation Team on June 26-30, 2006, and presents the Special Master's findings and conclusion regarding the Defendants' efforts to achieve substantial compliance with the Special Master's Plan for Community Mental Health Services and the Special Master's closing comments related to this case.

Relevant History

The relevant history of this fifteen year old lawsuit based on the Civil Rights of Institutionalized Persons Act ("CRIPA") is well known to the parties and has been set out in the preceding eleven Reports and Recommendations filed by the Special Master.

The Community Plan

An overview of the Special Master's Plan for Community Mental Health Services ("Community Plan") is contained in the Special Master's Tenth Report and Recommendation ("Tenth Report") filed on July 20, 2005.

Reports and detailed discussion concerning Defendants' progress or lack thereof to achieve substantial compliance with the Community Plan are set out in the Fourth, Seventh, Eighth, Ninth, Tenth and Eleventh Reports and Recommendations filed by the Special Master on July 18, 2003, August 26 and November 12, 2004, February 9 and July 20, 2005, and February 10, 2006, respectively.

Although entitled the Special Master's Plan for

Community Mental Health Services, the Community Plan was the result of a collaborative effort by counsel, representatives of the parties and Kris McLoughlin, the court appointed Special Monitor, along with Thomas Hester, M.D., Chief of the Adult Mental Health Division, Department of Health ("AMHD"). The meetings and discussions which lead to formulation of the Community Plan took place in Honolulu and Washington, D.C., during the fall of 2002.

The Community Plan was presented as part of the Special Master's Third Report and Recommendation filed on November 27, 2002, and was approved and adopted as an Order of the Court by Chief District Judge Ezra on January 23, 2003.

The deadline for Defendants' compliance with the Community Plan was originally January 23, 2005. On December 10, 2004, the twenty-four month period allowed for Defendants' compliance with the Community Plan was increased by seventeen months and Defendants' deadline was extended to June 30, 2006.

In the Tenth Report filed on June 20, 2005, the Special Master expressed apprehension and doubt as to whether Defendants were likely to meet the June 30, 2006 compliance deadline. Thereafter, counsel for the parties engaged in discussion and negotiation.

The Joint Stipulation

On October 26, 2005, Chief District Judge Ezra approved a Joint Stipulation And Order Regarding Plan For Community Mental Health Services ("Joint Stipulation") in this case.

The Joint Stipulation negotiated by the parties (1) recognized Defendants' progress and substantial compliance with the Hawaii State Hospital Remedial Plan, (2) promoted the efficient use of available resources and the provision of community based mental health services to consumers, (3) contemplated a more collaborative approach to Defendants with the Special Monitor and Evaluation Team members offering technical assistance to Defendants, (4) obligated Defendants to put forth their reasonable best efforts towards

achieving substantial compliance, (5) provided the best opportunity for Defendants to achieve substantial compliance with the Community Plan by June 30, 2006, and (6) ensured closure of this costly and very challenging fifteen year old lawsuit.

In pertinent part, the Joint Stipulation provided the following.

First, Defendants' deadline for compliance with the Community Plan remained June 30, 2006.

Second, Defendants were required to prepare an Action Plan with timelines which sets out the particular steps Defendants will take to achieve substantial compliance with the Community Plan. Third, the United States, Defendants, the Special Monitor and the Evaluation Team members would collaborate on the implementation of Defendants' Action Plan.

Fourth, Defendants would put forth their reasonable best efforts to achieve substantial compliance with the Community Plan and all previously entered court orders related to the Community Plan.

Fifth, in the event that Defendants did not achieve substantial compliance with the Community Plan by June 30, 2006, Defendants would continue their efforts to implement the Community Plan until on or before November 30, 2006. Finally, this lawsuit will terminate on November 30, 2006.

The Evaluation Team's Seventh Site Visit

Kenneth Minkoff, M.D., Gail Hanson-Mayer, A.P.R.N., B.C., M.P.H. and Paul Gorman, Ed.D. comprise the Special Master's Community Evaluation Team ("Evaluation Team"). Curriculum vitae for each member of the Evaluation Team have been attached as exhibits to previously filed Reports and are a part of the record and file in this case.

The Evaluation Team and Kris McLoughlin, the court appointed Special Monitor, were instrumental in facilitating Defendants' compliance with the Hawaii State Hospital Remedial Plan for Compliance.

During the period June 2003 through June 2006, the Evaluation Team assisted the Court by (1) conducting

community site visits, (2) examining Defendants' efforts and progress with regard to implementation of the Community Plan, (3) measuring Defendants' compliance, if any, with various aspects of the Community Plan, (4) conferring with Kris McLoughlin, the court appointed Special Monitor and (5) preparing written progress reports.

The seventh and final community site visit by the Evaluation Team took place on June 26-30, 2006. Dr. Minkoff made visits to Kauai and Maui Counties and Ms. Hanson-Mayer visited to Hawaii County. Copies of the written reports submitted by Dr. Minkoff, Ms. Hanson-Mayer and Dr. Gorman are attached to this Twelfth Report as Exhibits "A", "B" and "C", respectively.

In past visits, the Evaluation Team focused on certain items or areas of the Community Plan because of then existing "due-dates." During this final site visit, the Special Master asked the Evaluation Team to examine Defendants' completion and/or substantial compliance, if any, with regard to each section of the

Community Plan and applicable portions of the Hawaii State Hospital Remedial Plan for Compliance.

Initially, the Evaluation Team found many areas of the Community Plan complete. Most notable was Defendants' establishment of an array of services which included: (1) access to the Adult Mental Health Division ("AMHD") system, (2) psychosocial rehabilitation services, (3) crisis services, (4) support services (such as representative payee), (5) housing, (6) Mental Illness/Substance Abuse ("MI/SA") services and (7) treatment services (except as discussed hereinafter and below).

Other areas found by the Evaluation Team to be in substantial compliance included: (1) identifying guiding principles, (2) describing and reporting on the target population, (3) developing an information management system,(4) establishing a basic framework of operations and services at the community mental health centers ("CMHCs"), (5) establishing a provider quality monitoring system, and (6) filling many of the required

administrative and clinical positions described in the Community Plan.

However, the Evaluation Team also found that Defendants had not made meaningful progress and/or achieved substantial compliance in critical areas of the Community Plan.

Significantly, after reviewing information and documents which included (1) AMHD's own quality improvement data, (2) target population patient charts, (3) Hawaii State Hospital discharge records, (4) Sentinel Event documentation, (5) consumer grievances and (6) engaging in discussions with AMHD mental health consumers, AMHD leadership, CMHC providers and community purchase of service providers, the Evaluation Team could not state that members of the target population were receiving appropriate community services in all of the service areas identified in the Community Plan.

Shortcomings were noted in the following multiple areas: (1) forensic services, (2) treatment planning, (3) inpatient discharge oversight, 4) ACT services, (5)

case management services, (6) clinical/eligibility assessments, (7) individual, group and family therapy at CMHCs and (8) consumer protection.

This Report highlights some of the key areas noted by the Evaluation Team to be deficient or requiring Defendants' additional effort. For additional information, see the reports prepared by the Evaluation Team which are incorporated herein by reference.

One such area involves the development and implementation of community-based forensic services. See HSH Remedial Plan section I(1)(xi) and Community Plan section III.D.2.e.iv. At the time of the Evaluation Team's site visit, AMHD was without a permanent Forensic Director. Ms. Hanson-Mayer also stated, "The evidence of the development and implementation of a model for forensic practices throughout the service system was not present statewide ... There was minimal evidence of a monitoring program for forensic services. This would make sense in some ways as the [forensic services] program was yet to be

defined and implemented." Exhibit "B" at page 57.

For example, the first AMHD community-based conditional release program (the "Hale Imua" program) opened in March 2006. While this program appears promising, at the time of the Evaluation Team's site visit, Hale Imua, programs for community fitness restoration, services for jail/prison transfers and other related programs were incomplete and still in the midst of development.

A second key area of service development found in noncompliance was treatment planning, referred to by AMHD as "Recovery Planning". See Community Plan section III.C.1-3. At the time of the Evaluation Team's site visit, AMHD had developed a plan for system-wide training and implementation of treatment planning, a Recovery Manual had been developed and training had occurred. However, the system was not fully implemented. Dr. Minkoff stated in his report:

> " ...it is clear from the evaluation that compliance has not been achieved. In all the performance improvement audits conducted by AMHD,

> there was dramatic poor performance on recovery plans. (Admittedly, these were based on last year's records, but these are still the most current audits.) Further, current self assessments were uniformly not fully compliant. In addition, I review 36 recovery plans selected by AMHD from 20 providers and over 30 charts I reviewed had deficiencies related to the recovery plan standards in one or more areas. Particular concerns include: Timeliness...Crisis Plans...Recovery Orientation...Teamwork...[and] Family [involvement]."

Exhibit "A" at pages 23-24.

Ms. Hanson-Mayer also conducted individual record reviews and reached the same conclusions. Ms. Hanson-Mayer reviewed approximately 50 treatment plans. She expressed her concern about the adequacy of treatment plans by stating the following:

> "...this consumer made a serious suicide attempt while living in a care home. The record indicated this had also occurred at HSH. The root cause analysis at the time identified a language barrier as a precipitant. The treatment plan did not include a plan to ensure appropriate communication. There was no evidence of documentation to support an ongoing assessment of her level of risk or suicidal intent. The development of a coordinated crisis plan that included a mechanism to ensure regular communication between providers and involvement with community supports was lacking."

Exhibit "B" at page 17.

A third key area in service development which came up short is development and implementation of Assertive Community Treatment ("ACT"). See Community Plan section III.D.a.i. Over the years, AMHD has received much feedback about their ACT services. In essence, the overriding concern of the Evaluation Team and the Special Monitor was that Defendants' Assertive Community Treatment was ACT in name only and that the Defendants' ACT treatment teams did not follow, function or properly apply the Assertive Community Treatment model. Essentially, it was form without substance.

Dr. Minkoff summarized Defendant's compliance status with regard to ACT treatment as follows:

> "It is now well understood that ACT as an evidenced based practice is a comprehensive treatment approach, not a case management approach, and AMHD, in the last year, has begun to organize its implementation efforts to achieve real fidelity to the ACT model. Unfortunately, as with recovery planning, the ACT improvement efforts have begun too late in the sequence to have achieved successful implementation at this point in time. In order to make progress, AMHD has utilized consultation from Indiana effectively to provide training to ACT team on what ACT really is, have utilized the ACT fidelity scale to get real data on

> the level of fidelity of the teams, and has begun to create new utilization management definitions...However, at present, not one ACT team meets adequate fidelity criteria to be considered "ACT" according to the Indiana evaluations, and recent AMHD updates."

Exhibit "A" at page 29.

A fourth key area of system development found lacking is that of consumer protection. See Community Plan section IV.B.1.b. Dr. Gorman explained as follow.

> "AMHD has developed policies and procedures that are designed to respond in a timely way to incidents of abuse, neglect, death or serious injury to members of the target population when such events occur within AMHD covered services. The continuing problem is that AMHD does not follow its own policies. The Director of Quality Assurance acknowledged that sentinel events that are not absolutely critical in nature are not being attended to in the manner in which the policy indicates."

Exhibit "C" at page 40.

Ms. Hanson-Mayer also noted the following with regard to consumer protection.

> "During this review I met with several consumers on an individual basis. The concerns raised in each of these meetings focused on the lack of responsiveness to consumers who raise concerns regarding the appropriateness of care received. There was a fear that retaliation would occur if a consumer lodged a complaint against an AMHD

> provider. Consumers reported that complaints were not responded to in a comprehensive and timely fashion. The consumer office was seen as an extension of AMHD, not representing consumer concerns."

Exhibit "B" at page 49 - 50.

The Evaluation Team noted additional areas of non-compliance with the Community Plan related to AMHD system functions, organization and structure which support the provision of services. These areas of weakness and/or non-compliance included: (1) integration of recovery principles into the AMHD services system, (2) adequacy of staffing at the CMHCs, including hiring of MI/SA and case management coordinators, (3) timely completion of planning reports, (4) efficient operation of the Utilization Management department to ensure service continuity, (5) development of inter-organization agreements, (6) provider relations, (7) ability and authority of Service Area Administrators to ensure access to, quality of and continuity of services within their respective counties, (8) ensuring that

decision making is driven by clinical needs and (9) the establishment and maintenance of clear lines of clinical and administrative authority and accountability.

More specifically, staffing levels at the CMHCs affect AMHD's ability to provide adequate and appropriate services to consumers and continue to be a significant problem. See Community Plan sections III.D.1.a and IV.A.4.f and g. Dr. Minkoff wrote the following with regard to targeted case management consumer to case manager ratios:

> "Data provided regarding TCM case ratios at CMHCs indicates that the required ratio is not met in most clinics. This has been a long standing issue that has not been resolved...Most concerning, however, was direct reports from at least two CMHC managers (one in writing, in response to performance improvement review indicating that the ratio was not met) that there is currently no expectations for meeting the ratios, nor is there a specific plan for meeting the ratios."

Exhibit "A" at page 31.

Ms. Hanson-Mayer also stated her concern about the same issue:

"The ability of AMHD to meet the case management

> ratios has been a consistent concern since my initial evaluation. The data provided by AMHD to review supported that this remains a concern. The problem is threefold. (1) There are caseloads that exceed these ratios consistently across providers. (2) There are waiting lists for case management services, particularly ACT and ICM, which contributes to delays in consumers receiving the appropriate level of care. (3) The lack of progress in meeting the ratios, particularly within the CMHCs has contributed to staff job dissatisfaction and morale which in turn contributes to the high turnover in case managers. It is not uncommon to see that a consumer has multiple changes in case manager within a relatively short period of time."

Exhibit "B" at page 20.

Ms. Hanson-Mayer noted "at the time of this review the Case Manager Coordinator positions were not [all] filled." Exhibit "B" at page 42. Dr. Minkoff noted similar concerns about the MI/SA coordinator positions, "I continue to be impressed with the quality of the MI/SA coordinators, their teamwork, and their close collaboration with the MI/SA Service Director. However, I am concerned that there is an increase in the number of sites which do not have a MI/SA coordinator." Exhibit "A" at page 67.

The Evaluation Team noted areas of concern related

to the Service System Organization & Functions Section of the Community Plan. See Community Plan sections IV.A.1-2 and 3.c.ii and 3.e.iii(b)and(c)i and (c)iv. One specific area was the positioning of the Service Area Administrators ("SAA"). Ms. Hanson-Mayer explained as follows:

> "The positioning of the SAA within the AMHD organizational structure has recently shifted from reporting directly to the AMHD Chief to now reporting to the Chief of Clinical Operations. The effect of this change has impacted in the ability of the SAA to carry out the job description as defined in the Plan...The role of the SAA on the Executive Team was unclear...The SAA's lines of authority and accountability need to be clarified by the AMHD Chief in order for the SAA position to have a meaningful role within the system of care."

Exhibit "B" at page 34.

Dr. Minkoff added, "One issue[s], already discussed, is the concern by the SAAs that they have no authority in relation to the CMHCs." Exhibit "A"at page 55.

To be consistent with the original intent of the Community Plan, SAA's should have the responsibility and authority in the AMHD organizational structure to oversee all service providers in their respective

counties.

The Evaluation Team also questioned whether AMHD had satisfactorily established and maintained clear lines of clinical and administrative authority, accountability and the provision of supervision and guidance for administrative leaders.

As Ms. Hanson-Mayer noted, "The AMHD Chief has not adequately addressed the separation of the State's provider operations from the oversight function." Exhibit "B" at page 29. Dr. Minkoff emphasized, "[t]he importance of the administrative infrastructure in designing and supporting all the functions of the Community Plan is so significant that adequate performance is critical." Exhibit "A" at page 44.

The Evaluation Team identified shortcomings by the Defendants and areas of the Community Plan which were incomplete.

However, and importantly, the Evaluation Team also found that Defendants had made significant progress over the past six months, and particularly, in the three

months preceding the June 30, 2006 compliance deadline. The Evaluation Team noted that in many areas Defendants were headed in the right direction and encouraged Defendants to continue their efforts through November 30, 2006.

Conclusion

In conclusion, the Special Master is unable to say that Defendants achieved substantial compliance with the Community Plan on or before June 30, 2006.

However, the Special Master can state unequivocally that the amount and level of treatment, care and services available to persons in the community with serious mental illness has improved dramatically since the filing of this lawsuit. Due to the efforts of the parties and their counsel and the work of Kris McLoughlin, the court appointed Special Monitor, the integrated hospital-based and community-based mental health system contemplated by the "omnibus plan" approved by Chief District Ezra in January 2000 is approaching reality.

Hawaii State Hospital is no longer subject to the jurisdiction of the Federal Court and Defendants have made noteworthy progress and achieved compliance in many areas of the Community Plan recognized by the Evaluation Team.

However, the Special Master cannot disregard Defendants' shortcomings in the Community Plan areas of Service System Organization and Functions, core service areas such as Case Management and ACT; Forensic Services, Treatment Planning, Inpatient Discharge Oversight and Consumer Protection. There is no dispute that the foregoing items are critical to the establishment of the framework for a sustainable system of community mental health services contemplated by the Community Plan.

Based on the foregoing and carefully considering the purpose and intent of the Community Plan, the findings of the Evaluation Team and giving due weight to Defendants' progress and lack thereof in all areas of the Community Plan, the Special Master finds that

Defendants' lack of progress and/or non-compliance by June 30, 2006 in the areas specifically discussed herein above preclude a determination by the Special Master that Defendants have achieved timely substantial compliance with the Community Plan.

Defendants' deficiencies in the above-referenced areas should not diminish Defendants' successes and achievements in other areas of the Community Plan and the extraordinary efforts being put forth on a daily basis by the individuals working at Hawaii State Hospital, the Community Mental Health Centers and other service providers, the Service Area Administrators, the Service Directors and other key individuals at AMHD and elsewhere who continue to work hard to provide quality service to consumers, to develop the system of care and to implement the Community Plan.

Indeed, counsel contemplated a possible scenario in which Defendants were unable to meet the June 30, 2006 compliance deadline and expressly provided for it in the Joint Stipulation. The Joint Stipulation requires

Defendants to continue their efforts to implement the Community Plan until November 30, 2006, the agreed upon dismissal date for this case.

The Evaluation Team provided suggestions to Defendants with regard to areas of Defendants' nonfulfillment in their final reports. Defendants are proceeding in good faith with the requirements of the Joint Stipulation. The Special Master understands that Defendants have reviewed the suggestions made by the Evaluation Team and are in the process of finalizing a plan which will focus their continuing efforts between now and the November 30, 2006 termination date. The Special Master and the Special Monitor urge Defendants to follow the suggestions of the Evaluation Team and to continue with their good efforts. Momentum is certainly on the Defendants' side.

Therefore, and in accordance with the terms and conditions of the Joint Stipulation approved by the Court, the Special Master recommends that no further action be taken and that this case be dismissed on

November 30, 2006.

In closing, the Special Master recognizes and thanks the members of the Evaluation Team for their continued assistance and service to the Court. These three individuals have at all times acted in accordance with the highest professional standards and in the best interests of mental health consumers, the public and the parties.

The same is true with regard to Kris McLoughlin, the court appointed Special Monitor. Dr. McLoughlin[1] has a deep and unwavering commitment to the mentally ill and her community and she demonstrated same throughout her work as the Special Monitor in this case. The Special Master thanks Dr. McLoughlin for her perseverance, extraordinary work and expertise in this case. In so doing, Dr. McLoughlin has provided exceptional service to the Federal Court.

The Special Master also thanks counsel for their

[1] In May 2006, Kris McLoughlin completed her course of study and her thesis in accordance with university requirements and received a Doctor of Nursing Practice from Case Western Reserve University.

very professional approach and work in this case. After his appointment in 2001, the Special Master asked counsel to recognize a shared goal and to consider a collaborative approach in this case. At all times, counsel put acrimony aside and worked in the best interests of their respective clients and the public to bring this case to a negotiated conclusion and a positive outcome.

Lastly, the Special Master thanks District Judge Ezra for his support and leadership in this case. Judge Ezra identified the objective, set the tone and provided the Special Master with the opportunity to work with the parties to address the very important issues in this CRIPA based lawsuit in a collaborative way that would benefit the mentally ill and the community as a whole.

In closing, the Special Master requests that District Judge Ezra schedule a hearing on this Twelfth Report and Recommendation and allow the parties a reasonable opportunity to file comments and objections, if any, to this Twelfth Report and Recommendation. If

there are no objections or opposition filed by the parties to the Twelfth Report and Recommendation and its proposed approval, the Court may deem the matter appropriate for disposition without a hearing and issue an appropriate Order.

IT IS SO FOUND AND RECOMMENDED.

DATED: Honolulu, Hawaii, August 28, 2006.

KEVIN S.C. CHANG
United States Magistrate Judge