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Superior Court of Maine.

Paul BATES, et al. Plaintiffs
v.
Lynn DUBY, et al. Defendants

No. Civ.A. CV-89-088. | May 23, 2003.

Opinion

ORDER AFTER TRIAL ON DEFENDANTS' NOTICE OF SUBSTANTIAL COMPLIANCE

MILLS, Chief J.

PART I

***1** In February, 1989, patients at the Augusta Mental Health Institute (AMHI) filed a complaint against what is now the Department of Behavioral and Developmental Services (Department), the Commissioner of the Department, the Department of Human Services (DHS), the Commissioner of the DHS, and the Superintendent of AMHI. The class was certified in June, 1989 and included patients at AMHI on or after 1/1/88, all patients who will be admitted to AMHI in the future, and class member public wards. The members of the class alleged violations of rights resulting from inappropriate treatment at AMHI and inadequate community support services.

In August, 1990, a Consent Decree was signed to end the litigation. By signing the Consent Decree, the defendants promised to take the affirmative action specified in 259 paragraphs of the Consent Decree. On January 25, 2002, the defendants filed a notice in court, in which they alleged that they had taken that action and that they were in substantial compliance with the Consent Decree. The plaintiffs did not challenge the defendants' compliance with 62 paragraphs. The defendants, therefore, had the burden of proving they had substantially complied with the remaining 197.

After a seven-week trial, at a cost of well over $700,000.00 to the taxpayers, the defendants proved that they were in compliance with 23 of the 197 paragraphs, leaving 174 promises to the class members unkept.

The overwhelming evidence in this case shows that the defendants have developed a system that relegates non-class members with mental illness to second-class status. Non-class members are placed on waiting lists for services while class members are moved automatically to the top of that list. This does not mean that class members are receiving the services they need but it does mean that non-class members are receiving significantly fewer services than class members. Such a two-tiered system has not achieved substantial compliance by any standard; that system has failed.

The evidence shows that forensic patients at AMHI are warehoused with no support workers, no discharge date or plan, and little instruction about what they must accomplish for release. Patients who need hospitalization are denied admission at AMHI because it does not have the staff or the beds to accept the patients. Patients who are ready for discharge and whose discharge would make a bed available remain at AMHI because the resources they need to live successfully in the community are not available.

People who live in the community require services and supports that are not provided because the defendants cannot identify or address those needs. People in crisis wait in emergency rooms for crisis workers who, with minimal education and training, are asked to do extraordinary tasks. Some of those in crisis are involuntarily admitted to a hospital in spite of their consent to a voluntary admission. Some who need only to talk to a counselor are forced to agree to a voluntary admission because they will be involuntarily admitted otherwise.

***2** The defendants have produced volumes of data. Because they have failed to establish any standards by which their performance can be measured, the data simply describe events and cannot be used to allocate or develop resources.

This is not a failure of funding. The evidence made clear that until the recent budgetary problems, money for Consent Decree purposes was consistently provided by the Legislature.

This is a failure of management to get the job done.

As of 1/25/02, the defendants were not in substantial compliance with the Consent Decree and Settlement Agreement.[1] Because of this conclusion, the class members and the people of Maine require answers to the following:

1. Why have the defendants been unable to comply

in almost twelve years with the Consent Decree, which specified compliance by 9/1/95?

2. Why didn't a representative of the defendants or the Office of the Attorney General have the knowledge, the foresight, the candor, and the courage to admit, when the court itself moved the question, that the defendants were not in substantial compliance?

3. What should be done now?

PROCEDURE

The complaint in this case was filed on 2/27/89. The class action was certified by an order filed 6/21/89. The Consent Decree, which incorporates the Settlement Agreement, was signed by the court on 8/2/90. Paragraph 9 of the Consent Decree requires the defendants to have achieved substantial compliance with its requirements by 9/1/95. By orders filed 9/7/94 and 3/11/96, the court found the defendants in contempt of the provisions of the Consent Decree.

On 1/15/02, the court moved on its own motion to determine whether the defendants were in substantial compliance with the Consent Decree and whether the defendants were in contempt of its provisions. On 1/25/02, the defendants filed a notice of substantial compliance. *See* Consent Decree, ¶ 10. The plaintiffs filed objections and supporting factual evidence with regard to the vast majority of the paragraphs of the Consent Decree for which the defendants had claimed substantial compliance. *See* Consent Decree, ¶ 11. Accordingly, the defendants had the burden of proving at trial that they were in substantial compliance as of 1/25/02 with the paragraphs of the Consent Decree specified by the plaintiffs. *See* Consent Decree, ¶ 12; *see also* 10/6/02 Order. These issues were tried to the court.

At the close of the defendants' case, the plaintiffs moved for judgment as a matter of law. Because of the volume of testimony and other evidence presented during the defendants' case-in-chief, the court took that motion under advisement. That motion is now granted with regard to paragraphs 16-19, 22-29, 32(b), 32(d), 32(g), 37, 40, 45-47, 55-56, 58, 69, 74, 76-79, 83, 92-100, 103-104, 113-114, 116-29, 150, 156, 158, 160-168, 178-179, 202-204, 206 (physicians, dentists, social workers), 208 (physicians, dentists, social workers), 209 (physicians, dentists, social workers, nurses), 211 (physicians, dentists, social workers), 216 (physicians, dentists, social workers), 250, 252, 257, and 269-271 of the Consent Decree. This ruling on the plaintiffs' motion for judgment as a matter of law is essentially academic. The court has now considered all of the evidence the parties presented and the decision outlined below is based on consideration of all of the evidence.

***3** The ruling on the motion for judgment as a matter of law is significant, however, because it highlights the flaws in the defendants' proof. The defendants were required to present evidence that proved compliance as of 1/25/02. Instead, the defendants presented, in large part, evidence about expected procedure and about events that occurred after 1/25/02.

The Decision to File the Notice of Substantial Compliance

After review by members of the Department of "thousands" of documents, which could not be identified at trial, Commissioner Duby determined to file the Department's notice of substantial compliance on 1/25/02. When asked to describe the factors used to determine substantial compliance as of 1/25/02, Commissioner Duby replied that without a specific figure provided in the Consent Decree, the standard should be whether the Department had come "most of the way ." Although she testified that the Department attempted unsuccessfully to get the Court Master to set specifics, she was unfamiliar with a 1991 memo from the defendants to the Court Master in which the defendants stated that standards did not have to be set.

Although Commissioner Duby believed that the Department had addressed deficiencies in the system prior to 2002, the necessary action had not been fully implemented by 1/25/02. She agreed that the decision to file the notice of substantial compliance was affected by the plaintiffs' statement that they would file a motion for contempt if the Department did not provide a date for substantial compliance and by the fact that the court filed an order to show cause. Commissioner Duby denied that the decision to file the notice was based on Governor King's campaign promise to achieve compliance during his two terms as Governor.

Lisa Kavanaugh has been the Superintendent at AMHI since January, 2001. AMHI is Ms. Kavanaugh's first supervisory position in a public mental health hospital. She had previously been the consultant for preparation for the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) survey. She had never operated under a consent decree. Ms. Kavanaugh met with the Commissioner, the systems operations group, and the senior management team to describe what had occurred since she became Superintendent. She believed the last major piece required for a claim of substantial compliance was the signing of the contract for after hours coverage, which was effective 11/1/01. After that, she concluded that all Consent Decree requirements with regard to AMHI had been sufficiently performed to support a claim of substantial compliance.

Superintendent Kavanaugh used the Consent Decree, data from the DHS and JCAHO surveys, input from senior staff, and her professional judgment and experience to determine that AMHI had complied with the Consent Decree requirements. *See* Defs.' Ex. 7. She did not have written standards for the AMHI requirements in the Consent Decree. She inquired whether AMHI was doing something or not and, if something was in place, whether it was reliable.

***4** She initially testified that she had gone through the Consent Decree paragraph by paragraph, collected data, and made an assessment. Later, she admitted that the first time she had reviewed the Consent Decree to determine the standards relied on for compliance was during the trial.

She also used various reports. She believed the latest ones were the reports to the Court Master dated October and December, 2001. In spite of the requirements of the Consent Decree, she admitted that for some provisions of the Consent Decree, AMHI collected no data. She was unable to recount the paragraphs for which no data was collected. She agreed in her deposition testimony that there were no written reports for every requirement in the Consent Decree pertaining to AMHI. For the paragraphs for which they did not have written reports, the standards used were determined by other regulatory agencies, including the DHS.

Superintendent Kavanaugh was asked to describe the standards used to measure compliance when she reviewed the Consent Decree paragraphs that applied to AMHI. After a recess, she testified as follows:

Paragraph 27 is a Consent Decree requirement done through the central office;

Paragraphs 44, 50, 55 involve Individualized Support Plans (ISPs), which are unique to the Consent Decree;

Paragraph 70 is a Consent Decree requirement; community support workers (CSWs) are unique to the Consent Decree and we track them independently;

Paragraph 76 is a JCAHO and DHS requirement but the Consent Decree is more prescriptive so we monitor for the Consent Decree;

Paragraph 77: the DHS and JCAHO require an individual to be multi-disciplined so we rely on JCAHO and DHS but our Performance Improvement Plan states we monitor for the Consent Decree;

Paragraph 78 is unique to the Consent Decree;

Paragraph 79 is DHS and JCAHO;

Paragraph 80 is specific to the Consent Decree;

Paragraph 81 is specific to the Consent Decree;

Paragraph 82 is date specific to the Consent Decree;

Paragraphs 81, 82: we rely on DHS and JCAHO requirements for treatment and discharge plans, although these requirements are not exactly the same as those in the Consent Decree;

Paragraph 134 is DHS and JCAHO standards, which we rely on but we also monitor for the Consent Decree;

Paragraphs 137 and 134 are DHS and JCAHO, in part;

Paragraph 138 is DHS, in part;

Paragraph 139(a): we got rid of the pipes; 139(b) we monitor for the Consent Decree; we also rely on DHS and JCAHO, in part, but the Consent Decree is more prescriptive;

Paragraph 143: JCAHO and DHS have policies but the diversion of patients is unique to the Consent Decree;

Paragraphs 145, 146, 147, 148, 149, 150, 151, 152 and 153 are unique to the Consent Decree;

Paragraph 150 is somewhat unique but DHS also monitors rights of recipients;

Paragraphs 151-153 are the Consent Decree, DHS and JCAHO;

Paragraph 153: DHS and JCAHO do not specify number of hours for leisure;

***5** Paragraph 154: we rely on DHS and JCAHO, which require all of these services;

Paragraph 155: we rely on DHS and JCAHO, although those standards do not list these services as the Consent Decree does;

Paragraph 156 is Consent Decree specific;

Paragraph 157 is DHS and JCAHO;

Paragraph 158 is Consent Decree specific;

Paragraph 159 is DHS and JCAHO but those standards do not deal with entitlement and basic human rights and do not specify day exercise;

Paragraphs 160 and 161: we rely on DHS and JCAHO;

Paragraphs 162-165: we rely on DHS and JCAHO;

Paragraph 165: psychiatric emergency is the Consent Decree;

Paragraphs 165 and 166: we collect risk management data;

Paragraph 167 is specific to the Consent Decree;

Paragraph 168: we rely on DHS and JCAHO but the Consent Decree specifies psychoactive medicine;

Paragraphs 170 and 171: we rely on DHS and JCAHO;

Paragraph 172 is unique to the Consent Decree;

Paragraph 173 is federal law;

Paragraph 174 is specific to the Consent Decree;

Paragraph 175: we rely on DHS and JCAHO but the requirement that we send the report to the Court Master is unique to the Consent Decree;

Paragraph 176 is federal law but the reference to AMHI is unique to the Consent Decree;

Paragraph 177 is DHS and JCAHO;

Paragraph 178 is unique to the Consent Decree;

Paragraph 179 is unique to the Consent Decree with regard to time frame but DHS and JCAHO require dental treatment;

Paragraphs 180, 181, 182, 183, 184 are common to DHS and JCAHO and we report these through ORYX;

Paragraphs 185 and 186 are unique to the Consent Decree;

Paragraph 187: we rely on DHS and JCAHO;

Paragraph 188 is specific to the Consent Decree;

Paragraph 189: DHS and JCAHO require a report;

Paragraphs 190 and 191: we rely on DHS and JCAHO, which require training;

Paragraph 198: we rely on DHS and JCAHO but the report to the patient advocate is specific to the Consent Decree;

Paragraph 199: we rely on DHS and JCAHO;

Paragraphs 202 and 203 are specific to the Consent Decree; all regulatory agencies require staffing numbers but do not specify the ratio as the Consent Decree does;

Paragraph 204: 90% is specific to the Consent Decree;

Paragraphs 205 and 206: we rely on DHS and JCAHO;

Paragraph 207 is unique to the Consent Decree;

Paragraph 208 is specific to the Consent Decree;

Paragraph 209 is specific to Consent Decree;

Paragraph 210: we rely on DHS and JCAHO;

Paragraph 211: we rely on DHS and JCAHO;

Paragraph 212 is implicit in what we are supposed to do;

Paragraph 213: we rely on DHS and JCAHO, which require orientation and training but specific to the Consent Decree is training with regard to the Consent Decree;

Paragraph 214: we rely on DHS and JCAHO but those standards do not specify number of hours or exact training areas;

Paragraph 216: we rely on DHS and JCAHO but the requirement of ten hours of training each year is unique to the Consent Decree;

***6** Paragraphs 217 and 218 are unique to the Consent Decree;

Paragraphs 219, 221, and 222: we rely on DHS and JCAHO;

Paragraph 263: we rely on DHS and JCAHO but those standards do not specify ISPs;

Paragraph 269: DHS and JCAHO have standards around informed consent but do not specify frequency of review;

Paragraph 270 is unique to the Consent Decree;

Paragraph 271 is unique to the Consent Decree but DHS monitors;

Paragraphs 275 and 279: we rely on DHS and JCAHO;

Paragraph 279: DHS and JCAHO standards require that we have appropriate reviews but do not require review of class members and do not require a database;

Paragraph 280 is unique to the Consent Decree.

The fact that a requirement is "unique to the Consent Decree" or "specific to the Consent Decree" or is

"monitored for the Consent Decree" does not identify any standard by which the Superintendent determined that AMHI was in compliance with the requirements of the Consent Decree.
Superintendent Kavanaugh had no benchmark for many of the requirements. If an area was not covered by DHS and JCAHO regulations, she used her professional judgment. If something specified 100%, her standard was 100%. She did not know which paragraphs of the Consent Decree require 100% compliance; she expected that other people would know. The JCAHO determination of "substantial compliance" requires a score of 85% or more and she would like AMHI to be better than that.

When asked specifically whether as of 1/25/02 there were deficiencies in AMHI's compliance with the requirements of the Consent Decree, Superintendent Kavanaugh responded that mental health is complex and there are always areas in which the hospital could do better. She refused to testify that there were any problems at AMHI. There were only "opportunities."

Since 11/7/01, Joan Smyrski has been the assistant to the Associate Commissioner for Systems Operations at the Department. According to Ms. Smyrski, she was "pivotal" in the decision to file the notice of substantial compliance. In April, 2001, the Department informed the Court Master that it would file for substantial compliance by the end of 2001. At the end of August, 2001, the Commissioner asked Ms. Smyrski to take the lead in reviewing compliance. In September, 2001, she and others "marched" through the Consent Decree, paragraph by paragraph, with oral presentations and reviews with 50 employees. Legal counsel, a Consent Decree Coordinator (CDC), and Ms. Smyrski reviewed the results. The October and December quarterly reports issued. *See* Pls.' Exs. 67, 89. Some areas needed "minor work" and four areas needed additional work to achieve substantial compliance; those areas were noted in the 12/01 report and cover letter. *See* Pls.' Ex. 89. These areas included CSW tracking in the inpatient setting, caseworker to caseload ratios, documenting counseling hours, and full implementation of the quality improvement (QI) system. From the end of December, 2001 through 1/25/02, the review team assured senior managers that they expected documentation to be in place for the areas that needed better clarification.

***7** For each paragraph, the team pre-identified an individual who had a history of reporting on that paragraph and that person was given lead responsibility. According to Ms. Smyrski, these individuals had concrete information and evidence to take to the Commissioner for her final determination. A majority of the time, however, the team did not review concrete data. The team asked only if it existed and in what form.

These individuals did not have a "particular number in mind" to measure substantial compliance because not everything was measured: "as clearly as we could define, we were either doing it or not doing it." For the majority of paragraphs that have no specific numbers, the team did not use an arbitrary number or any written guidelines. The team used instead the Consent Decree, historical perspective on growth, enhancements, and changes to service. In spite of her admission that this team had no standards and no guidelines and did not look at all of the documents, Ms. Smyrski stated that "we felt very good" and thought it was appropriate to file the notice of substantial compliance by the end of 2001 or the beginning of 2002.

Ms. Smyrski agreed that documentation for compliance, except for the four noted areas, was not included in the October and December, 2001 quarterly reports. They added the most important data to show compliance because they did not want to repeat previous efforts.

Incredibly, the Department did not solicit the opinion of Gerald Rodman, who has served as the Court Master for this case since its beginning in 1990, in making the decision to file the notice of substantial compliance. The Department did not consult Dr. Benjamin Grasso, who was the Medical Director at AMHI from the fall of 1999 through April, 2002. The Department did not consult Dr. Andrew Wisch, the Professional Services Coordinator at AMHI.

The testimony that the defendants filed the notice of substantial compliance because they believed they were in substantial compliance on 1/25/02 is contradicted by the defendants' witnesses' testimony and by the other evidence presented and is not accepted. By the time the court filed its order to show cause, the defendants had operated under the Consent Decree for nearly twelve years. More than six years had elapsed since the expected compliance date of 9/1/95. Faced with the plaintiffs' threatened motion for contempt and the court's own order to show cause filed on 1/14/02, the defendants apparently determined that the best defense was a good offense. For the reasons discussed below, the defendants were wrong.

Substantial Compliance

In determining whether the defendants have proved that they are in substantial compliance with the terms of the Consent Decree, the court considers the nature of the interests at stake and the consequences of noncompliance to those interests. *See Fortin v. Comm'r Massachusetts Dep't of Pub. Welfare,* 692 F.2d 790, 795 (1st Cir.1982). The interests at stake in this case are the appropriate, individualized, community-based treatment for persons with mental illness and appropriate treatment for patients who require hospitalization at AMHI. These interests are great and the effect of noncompliance is significant.

***8** The court considers further the language of the Consent Decree, the circumstances under which the parties agreed to be bound by the terms of the Decree, and its purpose. *See Rolland v. Cellucci,* 138 F.Supp.2d 110, 115 (D.Mass.2001). The Consent Decree was entered into by the parties to resolve the lawsuit pending against the defendants. *See* Settlement Agreement, ¶ 7. The purpose of the Consent Decree was to assure that conditions at AMHI and services provided to class members in the community meet constitutional, statutory, and regulatory standards, as applicable. *See id.,* ¶ 8. The defendants were required to establish and maintain a comprehensive mental health system that met the terms of the Consent Decree and that was governed by the principles of paragraph 32.

As the defendants argued in their 5/17/02 memorandum of law on substantial compliance, the court is also entitled to consider the defendants' good faith actions toward compliance. *See Bd. of Educ. of Oklahoma City v. Dowell,* 498 U.S. 237, 249-50 (1991). As discussed below, the court considers the history of this case, the defendants' dealings with the court and the Court Master, and the substantial time and resources devoted to this trial that could have been used to make real progress toward the goal of substantial compliance.

Finally, the court considers the eleven and one-half years that the defendants have had to achieve substantial compliance since the Consent Decree was signed on August 2, 1990. As noted, the Consent Decree shows that the parties contemplated a compliance date of 9/1/95. *See* Consent Decree, ¶ 9; Settlement Agreement, ¶ 274.

The defendants argue that the fact of DHS licensing, Center for Medicare and Medicaid Services (CMS) certification, and JCAHO accreditation demonstrates that AMHI has achieved substantial compliance with the Consent Decree. Although some paragraphs specifically reference professional or DHS standards, many do not. *See* ¶¶ 138, 177. Louis Dorogi, the Director of the Division of Licensing, was unable to comment on any relationship between licensure requirements and the Consent Decree requirements.

Further, these various standards were not well explained during trial. Ms. Kavanaugh explained the CMS certification as follows:

> CMS again works with the Department of Human Services division of licensing. As I understand it, licensing is essentially the agent for CMS in Maine. And as such, through that licensing process, they determine if we are certified. They recommend, CMS, that we be certified to participate in federal Medicare and Medicaid program. CMS promulgates federal, I guess they are regulations, there are about 140 regulations or standards that deal primarily with hospital admissions and treatment and billing type issues, and they're referred to as the conditions of participation. And a hospital needs to be certified to participate, as I said, in the federal Medicare and Medicaid program. So DHS does that. I would assume they have some sort of contract with the federal government....

***9** Notwithstanding the testimony of defendants' expert, Peter Pastras, that JCAHO is the "gold standard" and the two and one-half inch thick JCAHO manual introduced into evidence, there was little description of the JCAHO process or the meaning of JCAHO scores. More important are the very substantial medication errors, the failures in admission and discharge practices, and the inappropriate treatment of forensic patients, to name only a few deficiencies, that occurred at AMHI during JCAHO accreditation. Finally, the fact that the defendants have been found in contempt of the provisions of the Consent Decree twice while JCAHO accreditation was in effect, combined with the evidence in this case, serves to undermine the significance of this accreditation for the purposes of the Consent Decree. The fact that AMHI has a DHS license, a CMS certification, and JCAHO accreditation does not show substantial compliance with the Consent Decree paragraphs that apply to AMHI. *See Wyatt v. Rogers,* 985 F.Supp. 1356, 1429-31 (D.Ala.1997) ("the [JCAHO] survey process itself lends itself to abuse by the institutions and is riddled with problems ... The [JCAHO] surveyors therefore do not see the facility as it really is on an average day.").

The language and purpose of the Consent Decree support the plaintiffs' argument that substantial compliance must be assessed with respect to individual class members and not the class as a whole. *See Halderman v. Pennhurst State School & Hospital,* 901 F .2d 311, 324 (3rd Cir.1990). As discussed in this order, the fundamental concept of meeting individual needs pervades the Consent Decree:

> Class members are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a

> psychiatric label ... Class members have individualized needs which may change or vary in intensity over time and according to the individual's circumstances.

See ¶ 32(a), (b); *see also* ¶¶ 58, 98, 104. CDC Whittington described the ISP as the foundation for all treatment planning for adults with mental illness.

Commissioner Duby's standard of "most of the way" does not appear in the language the defendants bargained for in 1990 to avoid further litigation. *See Halderman,* 901 F.2d at 324. Clearly, the defendants have failed to show that a mental health system is in place and is meeting the needs of all class members who want services. The defendants also have failed to show that specific numerical standards have been met. *See, e.g.,* ¶¶ 55-56, 58, 65, 76, 80, 100, 153, 156, 202, 257.

The defendants argue that full or perfect compliance is not required, especially in light of more flexible standards in some paragraphs. *See* ¶¶ 101, 107. Instead, they argue that proof that "the defendants have in place a self-monitoring mental health system appropriately designed to address the individual needs of adults with mental illness in a manner adequate to meet constitutional, statutory and regulatory standards" and proof that such a system is functioning are required. *See* Defs.' Mem. of Law Concerning Substantial Compliance at 1-2; *Association for Retarded Children of North Dakota v. Schafer,* 872 F.Supp. 689, 708-09 (D.N.D.1995), *rev'd in nonrelevant part,* 83 F.3d 1008 (8th Cir.), *cert. denied,* 519 U.S. 993 (1996); *Kendrick v. Bland,* 659 F.Supp. 1188, 1191 (W.D.Ky.1987). Even accepting this lower standard, the defendants have failed to come forward with the proof they themselves identified as required.

***10** Finally, and most importantly, the defendants must have in place a system that meets the needs "of adults with mental illness." As noted above, the overwhelming evidence shows that, contrary to the specific mandate of the Consent Decree, non-class members have been relegated to second-class status and are placed on a waiting list for services while class members are moved automatically to the top of that list. *See* ¶¶ 32(g), 37.

Resources

The trial required seven weeks to complete: the weeks of October 28, November 4, November 12, and December 9 in 2002 and January 27, February 3, and February 10 in 2003. Eighty-six witnesses[2] testified, some more than once. Approximately 300 exhibits, many voluminous, were introduced for the court's consideration. Several members of the defendants' management were present in the courtroom for significant portions of the trial.

After the trial was concluded, the court requested a list of costs and staff and attorneys' fees incurred by the parties since 1/25/02 to prepare for and attend the trial. The plaintiffs incurred $135,120.16 in expert fees and other costs. Plaintiffs' counsel devoted 2557.4 hours to preparation for and attendance at trial. Plaintiffs' counsel's staff devoted 927 hours. ¶ 273.

The defendants incurred $147,102.67 in expert fees and other costs. One of the Assistant Attorneys General representing the defendants devoted 90% of her time to this case and the other, two-thirds of her time. Defense counsel's paralegals devoted 332 hours to this trial. Various employees of the Department and other agencies devoted 2111 hours to this trial. Applying very conservative figures for attorney, paralegal, and staff hourly rates and Assistant Attorneys General salaries, and excluding the defendants and agency employees' time, this trial cost well over $700,000.00 of the taxpayers' money-this, in Maine, in 2002 and 2003.

This financial cost resulting from the defendants' decision to file the notice of substantial compliance is significant. But more important costs were incurred. The emotional toll on the class members and their relatives who testified cannot be underestimated. Counsel represented that class members who had been expected to testify could not attend the trial because their conditions had deteriorated. Class members admitted at AMHI at the time of the trial requested to be subpoenaed to testify because they feared reprisal. One class member admitted at AMHI refused to answer a question because the Superintendent of AMHI was sitting in the courtroom; this class member said that she was put in a "tough spot" by testifying. One class member feared that he would go into crisis after his testimony because of the stress of testifying. The anguish on the faces of these witnesses, who are, as one said, "desperately" trying to face their challenges, was unmistakable.

The defendants' witnesses did not escape the burden of this trial. The defendants' management was present throughout the trial and the effect of that presence was pervasive. Many of the defendants' employees appeared apprehensive. Some would not admit facts that appeared in the defendants' documents. Many were unable to answer straightforward questions. An unfortunate example was Ms. Whitzell's testimony about mandatory overtime for nurses and mental health workers (MHWs) at AMHI, which Superintendent Kavanaugh admitted was in effect prior to 1/25/02. Ms. Whitzell initially declined to say that mandatory overtime was a "policy" at AMHI. She said overtime was a "practice." Eventually, she said that AMHI has a "policy regarding mandating that talks about the process we use when in fact we have to insist that someone at the hospital stays and works an extra

shift." She was asked whether as of January, 2002, AMHI was mandating overtime regularly to meet staff needs. She replied "that is possibly true." Ms. Whitzell is the Director of Nursing at AMHI.

The Defendants' Evidence

***11** The defendants had the burden of proving that they were in substantial compliance with the requirements of the Consent Decree as of 1/25/02, the date of their filing of the notice of substantial compliance. Prior to the beginning of trial, the parties stipulated that evidence relating to the time period after 1/25/02 was admissible but relevant only to any remedy the court may impose.

Little effort was made by the defendants during trial to educate the court with regard to applicable time periods for matters testified to by defendants' witnesses. Dates were a crucial issue. Throughout the defendants' witnesses' testimony, questions from the plaintiffs' counsel and from the court revealed that the defendants' witnesses had testified at length about events that took place after 1/25/02. In fact, as discussed below, significant portions of some witnesses' testimony, and the entire testimony of Dr. William Nelson, addressed post-1/25/02 events. Even after the trial, the defendants rely in their post-hearing memorandum and evidence grid on testimony and exhibits about post-1/25/02 events to show compliance as of 1/25/02. *See, e.g.,* ¶ 156 (relying on testimony of Dr. Nelson and Ms. Whitzell's discussion of 1/02-10/02 documentation of counseling hours).

Witness after witness for the defendants testified about theories and protocols and policies and procedures and expectations and assumptions. Some admitted they had no personal knowledge about the matters they described. Some admitted that the defendants were not in substantial compliance as of 1/25/02 with the provisions of the Consent Decree about which they were testifying. As Michael DeSisto, former Chief Psychologist at AMHI, said when discussing the defendants' failure to comply with paragraph 279, "you can not just say you are doing wonderful things; you have to show, you have to document." His observation applies to the defendants' presentation at trial as well.

The testimony of the defendants' witnesses, and in particular Ms. Sandstrum, Ms. Smyrski, Ms. Stover, Ms. Whitzell, Ms. Briggs, and Ms. Whittington, is considered by the court, in general, as a description about expected practice and procedure and not a description of reality. In many instances, the plaintiffs do not challenge that the defendants have procedures in place. The plaintiffs challenge what actually happens when a class member asks for services or goes into crisis or is admitted to AMHI.

The court has recounted these descriptions of the defendants' expected procedures for two reasons. First, to emphasize the difference between expectation and reality. Second, to underscore the defendants' noncompliance with the requirements of paragraph 279. If the defendants had designed "a comprehensive system of internal monitoring, evaluation and quality assurance" for the requirements of the Consent Decree, they could have presented that critical data as evidence at trial.

The court's consideration of the defendants' witnesses' testimony was seriously and negatively affected by their refusal to admit any deficiencies, even when faced with documentation of those deficiencies. Testimony from the defendants' witnesses that there are "no problems, only opportunities," that there are "no problems, only documentation errors," that there are no problems, only "training issues," and that a fact "is possibly true" in spite of overwhelming evidence of its truth, does not satisfy a burden of proof. Such testimony destroys credibility.

***12** Regardless of the reasons underlying the improvident filing of the notice of substantial compliance, that notice could have been withdrawn when, during discovery, significant gaps in the defendants' proof should have become obvious. As stated in Commissioner Duby's cover letter for the 12/31/01 Compliance Report, "[o]ur lawyers will complete their detailed assessment of BDS and DHS documentation of substantial compliance in anticipation of filing a notice of compliance in court once the Department completes the action steps referred to above." *See* Pls.' Ex. 89.

Instead, the court was asked to make that detailed assessment. The evidence shows that during the nearly twelve years since the Consent Decree took effect, the defendants have not determined standards by which compliance with the requirements of the Consent Decree will be measured. Many processes, procedures, and protocols are in place and data has been collected but the defendants cannot measure their performance. The concept of meeting the needs of class members is fundamental to the Consent Decree. The defendants cannot show that they can identify and meet those needs.

III. CLIENTS' RIGHTS: Paragraphs 16-30

The Department issued the Rights of Recipients of Mental Health Services (RRMHS) and the Grievance Process Guide. *See* Jt. Exs. 8, 9. The evidence reveals difficulties in implementing these provisions.

According to Ms. Whitzell, the Director of Nursing at AMHI, every patient at AMHI has the right to submit any concern the patient might have regarding the RRMHS. This is level 1 of the grievance process, which includes the majority of grievances. *See* Jt. Exs. 4, 8, 9. The

program service director meets with a patient to try to reconcile or fix the concern. Ms. Whitzell was aware of level 1 grievances and the response in writing from the program service director.

Ms. Whitzell was not aware of any level 1 grievances filed concerning patient's rights, visiting, telephone, mail, exercise of religion, or outdoor activities. The only process involved with a level 1 grievance involves the Program Service Director meeting with the patient and forwarding a report to various people. She reviews the response to the patient from the Program Service Director. On occasion, when she finds inappropriate responses from the Program Service Director, she asks him to do further follow-up or to change the response. This has been done during the eighteen months that she has served as Director of Nursing.

There is no organized way at AMHI to categorize level 1 grievances and there is no organized analysis of level 1 grievances. She did not know what the most common level 1 grievance was. Although she testified that she was not aware that patients are discouraged from filing grievances, that testimony is contradicted by credible testimony from class members, as discussed below.

In June, 2001 and July, 2002, Commissioner Duby determined that because the Department had no licensing authority with the Aroostook Medical Center and St. Mary's Hospital, the Department had no authority to compel these hospitals to do anything, including determining the outcome of a grievance. Mr. Dorogi was not aware of the Commissioner's policy. Commissioner Duby dismissed the grievances and referred the matters to the DHS. *See* Pls.' Exs. 2 & 3; *see also* Defs.' Ex. 80A. Commissioner Duby did not know whether the patients were class members. She did not discuss this matter with DHS Commissioner Kevin Concannon. In the RRMHS, which the DHS has incorporated into its licensing of hospitals, the Department's Commissioner is referenced as the decision-maker in grievances. *See* Jt. Ex. 4.

***13** The Commissioner's decisions were contrary to the terms of the Consent Decree. The fact that a patient is admitted to a non-state community psychiatric hospital not under contract with the Department does not affect the grievance procedures in the Consent Decree. *See* ¶ 282; Jt. Exs. 4, 8, 9. The RRMHS applies to all facilities. Absent any evidence to the contrary, the court assumes this policy would be applied to complaints as well as grievances. *See* ¶ ¶ 22-26.

With regard to the community side, Thomas Lynn, the Assistant Director of Children and Crisis Programs at the Community Health and Counseling Services (CHCS) in Bangor, testified that if his agency receives complaints, the agency follows the agency policy. The policy provides that the agency contacts the client if permitted to talk about the concern. If the concern is not resolved, a formal complaint is requested and the complaint proceeds through a formal grievance process. Information is recorded on the survey part of the quarterly report to the Department. The surveys are circulated to supervisors and at staff meetings. Leslie Mulhearn, Director of Acute Services at Mid-Coast Mental Health Center, agreed that if she has a complaint that she cannot resolve, it goes through the agency process. She talks to the executive director and the person is offered a grievance process. *See, e.g.,* Defs.' 65C, Rider E, 3BIA (Tri-County Mental Health Contract).

Dr. James Yoe, the Director of Quality Improvement (QI) for the Department, stated that the Quality Assurance (QA) piece of the grievance is the process: the level 1, formal grievance to the agency, is reviewed and resolved. If not resolved, it is appealed to level 2, which is handled by a designee of the Commissioner. The QI function of grievances involves the data tracking system that is maintained by his office. Bi-annually, a summary is produced about the types of grievances filed. The office summarizes patterns. The program QI team looks at issues and makes recommendations for reviews. *See* Jt. Ex. 12A (9/01). As discussed in section XVII, the evidence reveals serious deficiencies in the defendants' QA and QI processes. The Court notes further that no recommendation or rationale with regard to the fact that only 75% of the grievances filed in institutions met the required time frames. *See* Jt. Ex. 12B (9/01-2/02); ¶ 19. The community grievances were addressed in a timely manner. *See id.*

In addition, the comments in the summaries of the grievances provide, in general, little insight to the process. For example, comments such as "no justification for the complaint," "appeal found without merit," and "rights not violated" do not satisfy paragraph 27.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 16-20, 22-30 of the Consent Decree.

IV. PRINCIPLES GOVERNING A COMPREHENSIVE COMMUNITY MENTAL HEALTH SYSTEM: Paragraphs 31-32

This section provides both principles to guide the system and specific requirements. The introduction discusses principles but the paragraphs contain mandatory language. *See, e.g.,* ¶ 32(b) ("services must be delivered").

***14** AMHI's census has been reduced. *See* Jt. Ex. 18.

The defendants filed an Implementation Plan dated 5/3/96. *See* Jt. Ex. 1. The previous plan was dated

9/30/91. *See* Jt. Ex. 3.

Commissioner Duby agreed that as of 1/25/02, all services and flexible models to accommodate changes in class members' needs were not in place for all. *See* ¶ 32(b). The Commissioner was asked whether as of 1/25/02, all class members requiring a psychiatric hospital admission were hospitalized at the facility nearest their home and discharged to the community with all necessary supports as soon as possible. The Commissioner responded that the discharges were occurring appropriately; her belief is not supported by the credible evidence. She said that the location of hospitalization depended on whether beds were available and whether the community could provide the level of care required. She said no study had been done regarding the percentage of class members not hospitalized at a facility nearest their home, but the Department has some information about that. *See* ¶ 32(c).

She admitted that as of 1/25/02, not all class members were receiving treatment in the least restrictive available setting according to the least restrictive means appropriate to their needs. *See* ¶ 32(d). She did not know the number of such class members. She agreed that as of 1/25/02, there were people at AMHI who could have been living in less restrictive settings, if such settings had been available. That fact led the Department to develop supported living centers. *See* Defs.' Exs. 100a-d. These centers were developed during 2002; one facility had opened before 1/25/02. She was unable to answer whether there were people currently at AMHI who did not need to be there. Based on the evidence presented, it is regrettable that, according to Commissioner Duby, no one had indicated to her that there were people who were being hospitalized who could be served in the community if there were more services in the community. She stated that she had heard only disagreement among treaters whether a person should be in the hospital or in a crisis residence. She agreed that there were not enough crisis intervention services in place to avoid hospitalization.

Superintendent Kavanaugh was unaware whether the Maine Hospital Association guiding principles stated exactly that the hospital closest to a patient's home should be used when hospitalization is needed. *See* ¶ 32(c). She testified that AMHI, when called for an admission, encourages people to look for a bed closer to home. Pursuant to federal law, AMHI can inquire about that, but cannot require that. She believes that if AMHI has the capacity and capability, AMHI has to admit a person. Because AMHI is a tertiary resource, however, if someone is more appropriate for another hospital, the person should go there. AMHI beds are for a special patient population. For example, Spring Harbor is viewed as a less restrictive facility than AMHI Spring Harbor may not be closer to the patient's home.

***15** Christine Hall was admitted at AMHI in 1992 and again in 1999 or 2000. She currently receives services from the Assertive Community Treatment (ACT) Team at Counseling Services, Inc. (CSI). She previously had a CSW who changed jobs in 5/01. Ms. Hall was then told that all that was available to her was the ACT Team and she had no choice but to accept that. ¶ 32(b).

Ms. Hall resides in Kennebec County. She has been admitted at the Fort Fairfield facility in Aroostook County three times during 2002. She was involuntarily admitted to that facility the first time in August, 2002 for approximately five days. Two admissions to that facility in September, 2002 were voluntary. She was told that no other beds were available. ¶ 32(c).

Carole Hawkes has been admitted at AMHI several times beginning in 1987. The last admission was eight years ago. She has been at the Bangor Mental Health Institute (BMHI) and Acadia since those admissions. Her worker currently is Trish Heckel. Sheila Hall from Region II was her worker for five years and they got along well. Sheila Hall told Ms. Hawkes that she had graduated from the Intensive Case Management program, that she no longer met the program's criteria, and they had "fudged" to keep her on that long. Ms. Hawkes then went to Kennebec Valley Mental Health but did not like the worker assigned to her so she went to Mid-Coast. She told Alan Letourneau that she wanted Sheila Hall as her worker again but he said he could not do that for her. ¶ 32(a)-(b); *see also* Testimony of Hayes.

Phillip Tedrick is an emergency room doctor at Maine General Medical Center in Augusta. He has been the Assistant Director of the Emergency Room Department for seven years. He participated in the Initiative Group. Maine General contacts AMHI for admission of patients in the Augusta area or when the patient requests AMHI or has been there previously; AMHI rarely accepts the patients. For the patients refused by AMHI, Maine General will seek admission at St. Mary's, Mid-Coast, PenBay, Spring Harbor, Acadia, and occasionally BMHI. ¶ 32(c).

The testimony regarding the 150-day patients who were safe for discharge but remained at the hospital as of 1/25/02 because community services were unavailable shows that patients are not receiving treatment in the least restrictive setting. ¶ 32(d); *see* Defs.' 31A. The testimony of the class members, their relatives, and the defendants' witnesses shows that the requirement of delivery of services based on identified individual needs is not being met. ¶ 32(e). The testimony of Ms. Diamond and Ms. Donoghue show that class members are not living in the communities of their choice. ¶ 32(f).

Two separate paragraphs provide that non-class members shall not be deprived of services because they are not

class members. *See* ¶¶ 32(g); 37. The overwhelming evidence in this case shows that the defendants are not in substantial compliance with these paragraphs. This failure is of very significant concern to the court.

***16** By Commissioner Duby's own testimony, class members are part of the priority population and receive services regardless of whether they meet acuity or other criteria. Non-class members must meet functional ability criteria and many who do meet that criteria are on waiting lists for community services. The Department has not done a study to determine the percentage of class members who would fall into the definition of a priority population if they were not class members. Commissioner Duby was not aware of any reports with regard to unmet needs of non-class members. ¶ 32(g); ¶ 37; *see also* Testimony of Hardy, Rockett, McClellan, Wheeler, Sandstrum, and Kluzak; Jt. Ex. 22, p. 73650 (non-class member wait list).

Based on the testimony of Ms. Kluzak, the Region II Housing Coordinator, the defendants were not complying with the requirement that class members have the right to refuse all or some services offered. ¶ 32(h); *see* Pls.' Ex. 43.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 31-32 of the Consent Decree.

V. DEVELOPMENT OF A COMPREHENSIVE MENTAL HEALTH PLAN: Paragraphs 33-48

Commissioner Duby believed that the Consent Decree provided some barriers to her ability to develop a comprehensive mental health system. She had not, however, taken any action regarding those perceived barriers and had not asked the Department's attorneys to seek any amendments to the Consent Decree.

The Department is organized into four programs: (1) the Office of Substance Abuse Services (OSA); (2) children's mental health services; (3) adult mental health services; and (4) developmental services. The Department oversees the two psychiatric hospitals, AMHI and BMHI. The Department also runs the Elizabeth Levenson Center for children and the Freeport Town Square and Aroostook Residential Center for mentally retarded persons.

The Department has divided the State into three regions: (1) Cumberland and York Counties; (2) Franklin, Oxford, Androscoggin, Somerset, Sagadahoc, Knox, Waldo, and Kennebec Counties; and (3) Aroostook, Piscataquis, Penobscot, Washington and Hancock Counties. The regional offices are organized like the central office and include a Regional Director; Medical Director; QI Manager; Utility Review (UR) nurse, new since 1996; mental health, mental retardation and substance abuse team leaders; CDCs, who since 1996 oversee the responsibilities of the Department under the Consent Decree and teach people about the Consent Decree requirements; Intensive Case Managers (ICMs), new since 1996; and QI management. The Office of Program Development was created two years ago in order to cooperate with the University system to be on the "leading edge of services." The Office of Consumer Affairs is designed to hear the consumer voice and to bring that perspective to policy decisions. *See* Defs.' Ex. 1 (Department's Directory of Services dated 7/02, created in 1999 or 2000 to educate Committee on Health and Human Services.).

***17** Nancy Diamond is a case manager and certified rehabilitation RN. Since 1989, she has worked at Lakeview Neurorehabilitation in Eppingham Falls, New Hampshire, which is ten miles from the Maine border She works in the adult program and provides inpatient treatment to patients who are a danger to themselves or others. The program works with patients until they gain their maximum potential and then works to place them. Lakeview has a number of homes with various settings depending on the residents' behaviors.

Lakeview provides a wide variety of services on a sliding scale of supervision and support. Other group homes have been able to provide the services that Lakeview provides. If other group homes do not provide the services Lakeview provides, that failure is a training or funding issue, according to Ms. Diamond, who observed that it comes down to "staff levels, teaching, and tolerance."

Lakeview serves Maine residents frequently, many with a diagnosis of mental illness. Ms. Diamond's average caseload is sixteen. Eleven of her sixteen clients at the time of her testimony were Maine residents; two were class members, both of whom were listed on plaintiffs' exhibit 57. She has served approximately twenty or more Maine residents and seven to nine of them were class members. The percentage of patients at Lakeview from Maine is between 33%-40% and the percentage can be higher at any given time. Visits from the Department's staff to Lakeview were exclusively for children and adolescents and not for adults. The average rate at the Lakeview main house for a Maine Medicaid client is $264.00 per day.

Ms. Diamond testified about patients at Lakeview. *See* Pls.' Ex. 57 (confidential list of names of patients). She was the clinical manager and case manager for five years for patient # 1. This patient's diagnosis was bi-polar disorder with a head injury and his disabilities included violent and sexually inappropriate behavior. He was discharged to Lakeview Community Group Home in the spring, 2001. He returns to the main house for services but not to reside. Ms. Diamond did not advise him that he could live in a home with fewer than eight people. ¶ 96.

Ms. Diamond had contact with the Department's service people with regard to patient # 1. His primary ICM was Jeff Herrick, with whom she was in contact for six months. Mr. Herrick told her that there were very few services available in Maine for people with traumatic brain injury. There was no ability to assist someone through a violent episode; such an episode would be handled at the emergency room or by the police. Patient # 1 had a guardian, who participated in efforts to place him in Maine.

Ms. Diamond was patient # 2's nurse and current case manager. This patient has Turret's Syndrome and obsessive compulsive disorder. Her mother and sister were the patient's guardians and were quite involved with her care. She self-injured frequently and was very anxious. She was at AMHI for a period but was not admitted to Lakeview from AMHI.

***18** This patient lived in the main house on the main campus at Lakeview; this house had more than eight residents. Lakeview recently told this patient that she could live in a place with fewer than eight people. She had a discharge plan to return to her parents. Two years ago, she began to look for a place to live after discharge and to start services. Her chart provided that discharge was pending development of appropriate services in Maine. Lakeview looked for two years for those appropriate services and contacted many people, including Lisa Wallace and Mary Tagney, who work at the Department coordinating Consent Decree services.

After many requests for services for patient # 2, they obtained an interview at CSI in 2000. They requested counseling services, community reentry, and case management services. A female counselor was requested for patient # 2. There was a great deal of dialogue concerning the source of payment for patient # 2's community care and finances played a part in placement.

Patient # 2 was placed on a waiting list for therapeutic counseling services for four months with CSI. Patient # 2 received counseling for three months, but the counselor left and the counseling terminated. There was no effort from the Department to find a less-restrictive setting so the patient was offered a placement at Lakeview. By the spring of 2002, she was receiving counseling and case management services at Lakeview. She did not receive case management services from CSI until 6/02. The CSI case manager for this patient visited Lakeview once because she was in New Hampshire for other reasons; treatment planning meetings for this patient took place monthly. A plan dated 11/02 anticipated the purchase of a home for this patient and staff for the home. At the time of Ms. Diamond's testimony, this patient had no discharge date from Lakeview.

Ms. Diamond was patient # 3's nurse and clinical manager. He was first admitted to Lakeview in the mid-1990s and had four admissions since that time. He is bi-polar with a head injury. He had been treated at various community placements in Maine and Pennsylvania, including the VA hospital. He was at a group home in Portland but had two episodes of violence and was admitted to AMHI. When he tried to reenter the community, he failed and was sent to Lakeview. He returned to the main campus. A discharge plan had not been developed for this patient. Ms. Diamond spoke to Sharon Arsenault, the Consent Decree worker in his area and requested case management and community reentry services. Ms. Arsenault said she would get back to Ms. Diamond. In an e-mail, Ms. Arsenault stated that it was not in her schedule to help patient # 3. Ms. Diamond e-mailed Ms. Arsenault several times but the guardian for patient # 3 did not push the issue, so Ms. Diamond discontinued her efforts.

Ms. Diamond was nurse, clinical manager, and case manager for patient # 4, who was at Lakeview from the mid-1990s through 1/30/02. This patient has a seizure disorder, brain injury, and delusions. She was on the psychiatric ward at Maine Medical Center in the fall, 2000 and returned to Lakeview.

***19** Mary Tagney told Lakeview to contact CSI regarding this patient. Lakeview made the contact but was not able to obtain services for patient # 4. Ms. Diamond spoke to many people and finally with Ron Paquette at CSI. He stated that patient # 4 was not suitable for community reentry. Mary Tagney and various other people from the Department stated that the Lakeview discharge plan was inadequate. Ms. Diamond tried to explain to them that Lakeview needed the help of the Maine people to do the discharge plan.

Six months after Ms. Diamond's contact with Mr. Paquette, a CSW was appointed for patient # 4. A plan was prepared, including psychiatric services from CSI, and the assignment of a case manager. After her discharge on 1/30/02, there were challenges in maintaining in-home supports to help keep patient # 4 in the community. She received no respite care. The case manager referred her to Lakeview for respite care but Lakeview required funding because it had not received funding when patient # 4 was admitted to Lakeview from Maine Medical Center. Lakeview was not providing respite care for this patient at the time of Ms. Diamond's testimony. Ms. Diamond has had contact with patient # 4 since her discharge because follow-up is done regularly at Lakeview.

Ms. Diamond's testimony makes clear that the defendants are not in compliance with paragraph 34. *See also* Testimony of Gianopoulos.

The testimony discussed in section VI shows that the

defendants were not in compliance with paragraphs 36, 38, and 39. The defendants' noncompliance with paragraph 37 is discussed in section IV.

Superintendent Kavanaugh testified that she believed AMHI was in compliance with paragraph 40 but she did not specifically determine that there was compliance with this paragraph. She would rely on the Medical Director for that determination. As noted, the current Medical Director, Michael Nelson, did not testify about any events prior to 1/25/02. The Superintendent then said she was not the best person to answer the questions and would have to check. She assumed the policies were consistent with the Consent Decree.

Based on the policies in effect at AMHI on 1/25/02, the defendants were not in substantial compliance with the requirements of paragraph 40 of the Consent Decree with regard to forensic patients. *See* Pls.' Exs. 7 & 8; Jt. Ex. 14; *see also* Testimony of Cox.

Doreen McFarland is a certified psychiatric nurse and RN at AMHI, where she has worked for eighteen years. She works the 7 a.m. to 3 p .m. shift. She attends treatment planning meetings and helps transfer patients to the community. She has contact with patients every day and is in charge of twenty-four patients.

She was previously the charge nurse at the medical clinic and at Stone South Upper at AMHI. She then worked at the psycho-social rehab at AMHI, which closed, and is now at Stone South Middle.

Ms. McFarland testified about efforts to transition nine patients from AMHI to the supported living services (SLS) facilities. *See* Defs.' Ex. 114 (confidential list of names). Very few dates were provided by Ms. McFarland for the matters she testified about.

***20** Patient # 1. Ms. McFarland had known this patient for seventeen years. The patient resided at AMHI on Stone South Upper. He had a history of assaultive behavior. He was 45 or 50 years old. He said that AMHI was his home.

This patient had problems with law enforcement in the past in Cumberland and York counties. There was very little family involvement with him. Three or four years before Ms. McFarland's testimony, he began to stabilize and he was now less threatening and more friendly. She began talking to him everyday about leaving AMHI and encouraging him to try to leave. He believed he was safe at AMHI and that bad things happen outside AMHI. She thought that if he went to a house on the grounds, he could visit staff and not be afraid. She explained to him that he would have his own room, he would have food that tasted good, could go into the community, and could come and go. On some days, he seemed interested in the move. She met with the staff at the facility and encouraged the staff to meet the patient. She took him to visit the facility on two occasions and he picked out a room. One day, he decided to move. He has not returned to AMHI. He liked the facility and enjoyed his freedom.

Patient # 2. She had known this woman for five years. She is 60 to 62 years old and single. The DHS was her guardian. Her mood and behavior varied.

This patient was not put in seclusion because of her age and her medical condition. Instead, when the patient was not acting appropriately, she would be sent to her room and someone would sit by the door. She was told she could come out when she was able to maintain control. If she decided to come out but she was still agitated and not in control, they staff offered her medicine. This was not documented as seclusion because, according to Ms. McFarland, this patient was not prevented from coming out of her room.

In order to leave AMHI, this patient needed medical and psychiatric help in a supervised, small group home. In the treatment team meetings, her goal was to live with her sisters, but that was not realistic. Her goal then was to have an apartment. The team knew that that also was not appropriate and would be unsafe for her even if the staff visited a few times each day.

She finally moved to the Sabattus house. Her guardian told the people at AMHI to take this patient to the new setting and she would be fine. She had not returned to AMHI and she liked the Sabattus house.

Patient # 3. Ms. McFarland had known this patient for three years on the psycho-social rehab unit and for five years on Stone South Middle. This patient was 45 years old and his guardian was the DHS. This patient stayed in bed most of the day and got up at night. He was sexually intrusive, both physically and verbally.

This patient needed twenty-four-hour supervision. He had no contact with his family. Because he preferred a Portland apartment, he turned down living in a group home in Augusta. The DHS guardian wanted him to go to a house on the AMHI grounds. He moved to Riverview I on the AMHI grounds and had not returned to AMHI as a patient or a visitor.

***21** Patient # 4. She had known this patient for four years. He was 55 years old, smoked, was not social, and he was very fearful of others. His guardian was the DHS. He was placed in a Farmingdale home for a period, but returned to AMHI. He refused to go anywhere and said that he would either live at AMHI or he would live on the street. He was not interested in being placed outside of AMHI. Because of the time he spent on the street, he was very fearful that he would have no food if he left AMHI.

Finally, after showing him pictures of refrigerators full of food at the proposed facility, the patient went to Riverview II. He had not returned to AMHI as a patient.

Patient # 5. Ms. McFarland had known this patient for 10 years consistently and 18 years off and on. This patient was at Stone South Middle. He was highly intelligent, 55 to 57 years old, and a Bowdoin graduate. He had minimum participation in group counseling and minimum interaction with others. DHS was his guardian, although he denied that fact.

He had no interest in leaving AMHI. He said he needed asylum because the Mafia was after him and if he left AMHI, electric boats would get him. He liked to go to Barnes & Noble and McDonalds. There had been no previous attempts to place him. He visited Riverview I but was not interested because he thought it was not safe. He had been discharged several times but returned to AMHI.

On 11/18, presumably 2002, he was discharged but returned 12/3 from Maine General Medical Center. He left the facility because he believed that demons and the Mafia were there. He said that demons were at AMHI also but he came back for asylum. He was at AMHI at the time of Ms. McFarland's testimony and efforts continued to place him again. He wanted to live in an apartment but they cannot assess whether he would be able to cook for himself because he does not participate in any groups. There was a bed available for him at Sabattus.

Patient # 6. Ms. McFarland had known this patient for 17 or 18 years. He was in his early 40s and had been hospitalized for a long time. He knew he was ill. His parents were his guardians. He had no CSW because, apparently, he had never asked for a CSW.

He was very difficult to place and placement will take time. He had an assaultive past. He was mostly stable but can get upset and angry and it took him a long time to form relationships with others. He had little participation in groups although he wanted to have a job.

He was very concerned about windows because he did not know what a real window was, without screens and bars, windows that open. When he visited the proposed facility, he opened the windows constantly. He liked the fresh air when the windows were open and said he liked the room. He went to a facility on a short leave for four days. He refused his medicine and said he was ready to return to AMHI. He had another short leave but returned again to AMHI. There was still a bed available for him at that other facility.

***22** The reviews for this patient from October through April, not including January, reveal that he did not attend any treatment team meetings. *See* Pls.' Ex. 44. The bottom one-third of the form, which includes sections regarding patient participation in treatment planning, discharge criteria, capacity status, was not filled out. Ms. McFarland did not know why nothing was checked on the discharge criteria but she signed off on the form. She said that she was not in the habit of signing off on incomplete forms. In the last two years, no one had examined the details of her record keeping. She is the supervising nurse.

There was also no signature on the forms by a psychologist or a CSW. On 10/01, a psychologist, Theresa Mayo, was on the unit. Ms. McFarland did not know why Ms. Mayo did not sign the forms. Although this patient did not have a CSW, there was no discussion in the treatment team meetings about enlisting a CSW to encourage this patient to leave the hospital.

The nurse's notes of 12/28/01 provide that 75 minutes of individual treatment time were refused by patient # 6. *See* Pls.' Ex. 45; ¶ 156. According to Ms. McFarland, there is no difference between individual treatment time and individual counseling. Counseling can include medication teaching or anything for a client's benefit. She had had no training about documenting individual counseling in the chart. She said she tells the nurses she supervises that treatment or counseling means medication teaching, using a washing machine, any interaction with the client on the unit "in a teaching mode," and any other one-to-one intervention. One-to-one intervention is considered treatment and counseling according to the license for a psychiatric nurse. She did not know how many psychiatric nurses are employed at AMHI.

She met patient # 6 several times for a total of one-half hour. She told the patient that his medications were available and why he needed them. Ms. McFarland described this as "med teaching." She said the same things to him several times per week. *See* Pls.' Ex. 46.

Patient # 6 routinely spent time in his room. She was not aware of standards AMHI uses to determine if a patient was responding to treatment. On one occasion, Ms. McFarland documented that the patient refused to meet with her but there was no indication how often she tried to meet with him. *See* Pls.' Ex. 46.

Counseling time was an ad hoc process for her and the other nurses. The patients had a daily schedule and the counseling time had to be fit in. She offered perhaps five minutes at different times. Although she stated that the nurses try to be innovative with what happens during the time with patients, sometimes they discussed the same things with the patients.

Patient # 7. She had known this patient for ten to twelve years. He was 62 or 63 years old and very close to his family. His brother was his guardian. He wanted to live on his own in Portland. No effort had been made to place him in Portland, apparently because his guardian wanted

him to live in Augusta. She did not know whether the guardian attended the treatment team meetings.

***23** Because the patient was very prejudiced against everyone, he was very difficult to place. He was referred to Sabattus for medical and psychiatric care; he had diabetes. He liked AMHI and had no interest in leaving. There was no longer a bed for him at the proposed facility because he mistreated a woman there. His brother wanted him returned to AMHI.

She had known patient # 8 for five years and saw him every day. He was 50 to 60 years old. He had no guardian but that issue was under study. He possibly had early dementia, which was being assessed. He participated in groups some days. He was placed at Sabattus for a while but was disruptive and returned to AMHI. There was no longer a bed available for him at the facility.

This patient was an archer. Ms. McFarland did not know if any effort had been made to get him involved in archery. The staff said he could have an archery set if he was in a safe placement. Archery was not incorporated into his treatment plan at AMHI.

Patient # 9 was 30 to 32 years old and enjoyed visiting her parents. DHS was her guardian. Neither placement in an apartment alone nor placement with her parents worked. At treatment team meetings, her mother discussed her desire for her daughter to live with her parents with in-home support.

At the time of Ms. McFarland's testimony, this patient lived at AMHI during the week and with her parents on the weekends. Her parents wanted her to live with them, but they wanted three hours per day to themselves so that they could have some "down time." That request was being considered.

During the past two years, Ms. McFarland was not aware of any outside independent consultants brought in to advise treatment teams with regard to encouraging patients to leave AMHI. She did not recall any mention in treatment team meetings of a consultant to call in for advice. Testimony from other witnesses, discussed below, confirmed that independent consultants were not used. ¶¶ 45-47; *see* Order dated 2/6/97.

As of 1/25/02, the defendants were not in compliance with paragraphs 33-34, 36-40, 45-47 of the Consent Decree.

VI. INDIVIDUALIZED SUPPORT PLANS: Paragraphs 49-83

A. Delivery System; B. Application/Referral for Services; C. Individualized Support Plan

The Consent Decree provides:

> The ISP is the principal tool through which class members are identified. It is, therefore, a critical element in assuring that the comprehensive mental health system is responsive to class members' actual needs.

¶ 72. Susan Whittington described the ISP as the foundation for all treatment planning for adults with mental illness. *See* Jt. Ex. 23, pp. 23 -27.

Class members are entitled to have an ISP and a CSW. Those services were supposed to be in place by 9/1/95. On 1/25/02, there were class members still waiting for these services. *See* Defs.' Ex. 66 (Wait List Data); *see also* Defs.' Ex. 46C (information on needs of class members not in service had "not been captured effectively" as of 2/02); ¶¶ 49-50, 74. Even as of the filing of the 12/01 compliance report, less than one month before their claim of substantial compliance with the Consent Decree, the defendants did not claim compliance with these fundamental requirements of the Consent Decree. *See* Pls.' Ex. 89, p.-16.

***24** Class members who are hospitalized are entitled to a CSW within two working days of the application. Class members who are not hospitalized are entitled to a CSW within three working days of the application. ¶¶ 55, 56. As discussed below, these important deadlines were not met by the defendants.

Once in place, the ISP must be reviewed no less frequently than every 90 days. ¶ 58. The testimony of Ms. Hayes and the defendants' documents show that this deadline was not met by the defendants. *See* Defs.' Ex. 64, Figure 9: ISP Document Review: Update and Review of Plans.

Class members have to be informed of their right to receive services and the RRMHS. The testimony of the class members and Ms. Whitzell show that this information was not always available. ¶¶ 53, 57.

The ISP, services, and the role of the CSW are based on the class members' actual needs. ¶¶ 61-64, 66-68, 70. Gerald Rodman has been the Court Master for the Consent Decree since 11/01/90. His valid concerns about the Department's ability to assess and meet actual needs are discussed below. The defendants' documents and witnesses' testimony and the class members and relatives' testimony confirm Mr. Rodman's concerns.

In spite of the requirements of paragraph 65 regarding the

class members' right to file a grievance about an ISP, the testimony shows that the Department believes that right to be contrary to the collaborative effort underlying the ISP process. ¶ 65. As discussed below, in spite of the express requirement for written service agreements, the Department has intentionally ignored this provision and has rewritten this paragraph. ¶ 69.

Ms. Whittington stated that the ISP was designed to be used throughout Maine, to be consumer-driven, and to meet the mandates of the Consent Decree, licensing, the Department, Medicaid, and consumer and agency needs. The goal of an ISP is to make sure that goals are measurable by, for example, using a time frame that is reasonable.

Mr. Rodman was called as a witness by the plaintiffs. Based on his experience and work in monitoring the Consent Decree since 1990, the court accords great weight to Mr. Rodman's testimony and opinions. Mr. Rodman concluded that the Department is not in compliance with the requirements of paragraph 62. The Department's articulation of goals in general is very broad and goals are discussed in terms of life domains. Goals are used in another, more narrow way, however, for the purposes of paragraph 62, which has an underlying concept that class members' needs are to be met. In order to meet those needs, services are to be developed and goals are to be established to provide the services that are needed to meet needs. Mr. Rodman concluded that the defendants had discussed exclusively the former, broad concept of life domain goals during their testimony at trial.

He asked the defendants to assess goals to determine whether the class members' needs were being met. The goal tracking study was in response to this inquiry and recommendations from Mr. Rodman. Initially, his concerns were that the Department was reporting very few unmet needs in any category of service. He was not convinced that that reflected how unmet needs were being met, especially regarding the defendants' definition of an unmet need as a need for which there is no resource. Mr. Rodman concluded, and the evidence shows, that the defendants have not specifically assessed the extent to which unmet needs are being met.

***25** The concept of meeting a person's needs pervades the Consent Decree. The Department was required to go beyond the consideration of whether there was a resource available and address the fundamental question of whether the person's need is actually being met. An ISP is a tool to meet people's needs, but if the need is not in the ISP, it has to be addressed outside of the ISP.

The goal study did not address Mr. Rodman's concerns. The principal reporting done by the defendants with regard to meeting needs came from the Case Management Application (CMA). Mr. Rodman told the defendants that the CMA was resource oriented: the CMA considered only whether there were, in the defendants' opinion, resources available to meet needs but the CMA did not assess whether identified needs were being met.

Mr. Rodman was also concerned about the defendants' treatment of goals, principally, the dissolving or ending of goals. The study made clear that a class member's goal could be dissolved if the class member moved or changed agencies or changed his CSW as opposed to if the class member left service or died. Dissolving goals for reasons other than leaving services or death affected the ability to track the period of time during which the goal remained open. The goal study focused on goals open for twelve months or more. If the goal was not met within one year, the goal was dissolved and would not be reflected in goals open for more than a year. That practice impacted the accuracy of the data and suggested, inaccurately, that goals had been accomplished within one year.

The Consent Decree established the ISP as a client-owned document, but dissolving goals without the client's choice was inconsistent with that philosophy. The goals were not written in terms that were measurable and it was difficult to determine whether a goal had been met. Mr. Rodman stated that the Department has "expressed an interest" in addressing this problem. The defendants had no reporting system regarding needs that a client may be addressing himself. In his efforts to monitor the Consent Decree, Mr. Rodman had no way to assess whether all needs were captured in the ISP.

Andrew Hardy has been a CDC for Region II for three years. His agencies include Tri-County Mental Health, the Intensive Case Management Program, Sweetser ACT Team and Community Support Program, and Mid-Coast Mental Health Community Support Services. Four hundred class members are served by those agencies. He has contact with class members primarily by phone. His contact involves class members' questions about the Consent Decree, education, housing, or calls for emotional support. He receives more phone calls from class members in and out of service after mailings. As of April, 2002, Bruce Samuels began taking calls from class members not in service.

A client is in service if he has a CSW. If a client receives only medicine from an agency, the client is not considered in service. Some class members call Mr. Hardy to say that they are not getting the services they want from the CSW. Some have specific needs, such as paying bills, housing, and transportation. Class members not in service call and request case management services. Contact with class members not in service is recorded in the activity log of the CMA.

***26** One and one-half or two years before his testimony, a

system was developed for class members who did not receive services. When a person calls to say he is not in service and has no case manager, this was documented as a "paragraph 74 issue." The reason for the call, in line with the ISP goal areas, was recorded in the activity log. If a notation is not made, however, the client would be "lost" and there would be no follow-up. Every six months, Region II counted the number of calls and the reason for the calls. Each Region has its own way to deal with paragraph 74 documentation. This information is brought to the CDC meetings and focus groups are conducted to assess for trends and to compare across regions. A written report is forwarded to the Regional Director, the financial team, and central office for use as resource development.

A chart was developed to show trends. *See* Defs.' Ex. 46B. The most recent chart does not contain a "comment column" as did previous charts. *Compare* Defs.' Ex. 46B *with* Defs.' Ex. 46C. The five most frequently identified areas of specific needs are housing, finances, other, dental, and transportation. The need for a referral to a case manager-CSW for a person not in service was recorded in "other." As noted above, this information had not, prior to 2/02, been effectively captured. *See id.* According to Mr. Hardy, the needs are the result of poverty issues and not necessarily with regard to mental health problems. He agreed, however, that mental illness issues link with poverty issues.

As of September, 1999, a process was in place to monitor the time period involved for referral of persons in the community for service. The person requesting the services calls the agency. There is, however, no tickler system to determine whether the consumer made the call to the suggested agency. Once an agency receives a referral, it sends information to the case managers on a monthly basis. If an agency cannot do a referral to a CSW within the required three days, the agency calls and the person is referred to the Department's Intensive Case Management program. *See* Jt. Ex. 25, pp. 67915-17. The wait list form in joint exhibit 25 was revised and implemented in February, 2002 and finally revised in April, 2002. A similar form was used from March, 1999 through December, 2001. Because agencies were confused about the time periods required in paragraphs 55 and 56, this form was revised to make the instructions more concise and to specify when the three-day period began. Based on this more accurate form, in place after 1/25/02, the agencies now know what to do.

The instruction that class members are automatically appropriate and eligible for services was in place as of December, 2001. *See id.* at 67917. The form was revised in February, 2002 to provide for a referral to an ICM if a person was on the list for more than four days. *See id.* at 67916. Mr. Hardy stated that if class members are waiting for more than three days, they call. He would not know if a class member was waiting for services and was not on the list unless the class member had previously called him. Class members continue to wait without services. There is a difference between the numbers on the wait list forms from the fall of 2001 to those on the lists for May through August 2002, after the revision. Because he receives the forms on a monthly basis, a person theoretically could have been waiting for services for thirty-four days before he receives the form. People are listed on the forms who are "still waiting" for services.

***27** Although the numbers for needs of class members not in service have increased, Mr. Hardy has done nothing because this was "not a trend." *See* Defs.' Ex. 46C, pp. 3-4. The numbers of needs for psychiatric medications increased from six to thirty-four. *See id.* at 4. Mr. Hardy considered these numbers are something to "watch" and he has not heard anything about what, if anything, will be done. Mr. Hardy reviewed defendants' exhibit 46C during his testimony. He recited the numbers from the form and stated, "that's all that I can say." This was clearly just data that is collected and circulated and had no particular meaning to Mr. Hardy.

Linda Santeramo has been a CDC for Region I, Cumberland and York, for six years. There are three CDCs in Region I. She is the liaison for five community support agencies including Shalom, Ingraham, Sweetser in Freeport, Community Counseling Services (CCS), and CSI. These agencies serve roughly 200-250 class members.

She testified that Region I has the same services described by Mr. Hardy for Region II. Region I records paragraph 74 issues on an activity log note and puts the note in a binder in the office.

Ms. Santeramo has direct contact with class members daily on the telephone. The class members respond to mailings and call about finances and problems with agencies. She has face-to-face contact with class members as well. Her role is to link class members to services.

The CDCs are expected to work with the agencies on problem ISPs. Ms. Santeramo calls the supervisor or the CSW to discuss the ISP or she can involve the mental health team leader, Claire Harrison.

Ms. Santeramo receives the waiting list and reviews the lists "to see if the math adds up." A duplicate name or a person waiting for services with no interim worker provided is flagged and the agency is contacted. Data are entered and put in a binder. She has not done a comparison of the wait list data for the fall, 2001 through the summer, 2002. She said "I just do the forms" for the agencies that she covers. She reviews agency requests to terminate clients for the agencies she covers.

The QA Department Goals Study Project looked at all client goals for fiscal year 2001, including the types of goals and frequencies. The CDCs were involved in looking at goals for more that twelve months to determine why the goals were set for that length of time.

Dr. Yoe developed the goal study method, discussed above. *See* Jt. Ex. 22. This study was completed January, 2002. There were 114 open goals. Six months later, well after 1/25/02, the Department took second look. Of the 114 open goals from the first study, 56 were still open. *See* Defs.' Ex. 45. The 90-day summary narrative describes the status of the goal. Needs were determined to be unmet if no resources were available to service the need or if a person was on a wait list for services. During the study, the CSWs and clients were not contacted for input; the determination that "identifiable progress" had been made on goal compliance was based on the 90-day reviews and notes only.

***28** Those involved in this study concluded that for the 56 open goals, there were no unmet needs; 69% were "maintenance long-term goals." Ms. Santeramo concluded that this reveals only an ISP "training issue" for CSWs because the goals remain open for more than twelve months. The goals should be written as action steps in more measurable periods. Goals should not continue year after year because the class member sees no progress.

In phase two of the goal tracking, Ms. Santeramo testified that "Goals Disposition at CDC Review" was based on letters and the ISP. *See* Jt. Ex. 22, p. 73646. They did not consider whether unmet needs were involved. In addition, they identified progress made on goal completion but did not consider dissolved goals. They did not consider why 22.9% of the goals were dissolved. *See id.* She agreed that after the fall, 2001 statewide study, it was concluded that term "dissolved" was used too often. The recommendation was more training and a more thoughtful look at long-term measurable goals. The term "dissolved" is still, however, being used for goals.

Ms. Santeramo participated in contract review for CSI a few months prior to her testimony. They addressed the waiting list for services and getting clients to the agency on time. She does not attend contract review meetings for her agencies consistently. She attends only if there are issues she wants to address. She did not recall if she attended contract reviews at the end of 2001 and has attended only one in 2002.

Although Ms. Santeramo testified on direct examination that the data entry person had stopped tracking problems with ISPs because they were up-to-date, on cross-examination she agreed that there was a backlog of about fifty ISPs until a few months ago, or until fall, 2002. These were tracked for four or five months until they were caught up. She agreed that there "could have been" a push by the Department to clean up problems with ISPs at the end of 2001 and the beginning of 2002.

One of the plaintiffs' experts, Katherine Hayes, works for H & W Independent Solutions in California, which provides training and consulting in the disability field. She has a B.A. in psychology and M.A. in counseling. Ms. Hayes teaches providers how to understand regulations with which they are required to comply.

The Disability Rights Center (DRC) asked Ms. Hayes to review ISPs to determine how the plans are implemented in terms of service planning and placement in the community. *See* Pls.' Exs. 76-79. She reviewed information regarding the guidelines in place in this court case, training materials provided to case managers; Maine regulations, the RRMHS, and reports by the Department. She initially reviewed 100 ISPs. *See* Pls.' Ex. 76. Ultimately, she reviewed 442 class member ISPs; she suggested a review of 8%-10% of the active ISPs at the time of her review. *See* Pls.' Ex. 77. She performed a separate analysis of 108 people who went into service after 12/31/00. *See* Pls.' Ex. 79. Because some clients had multiple ISPs, she reviewed approximately 3000 ISPs in total. She also employed another person with surveying experience to review ISPs with the form used by Ms. Hayes to determine whether the data collection was accurate.

***29** Ms. Hayes reviewed a random sampling of ISPs because she wanted a cross-section of people served. She employed a standard method to add people to the sample if a particular issue was not represented by the initial sample.

She did not have information on class members in the Intensive Case Management program. The ICMs provide no direct services except case management. If a client receives Intensive Case Management services, any other services received would not be provided by the Intensive Case Management agency. She disagreed that her survey was simply reflective of Intensive Case Management services because various regions, agencies, and clients who were not in the that program were represented.

The court is satisfied that Ms. Hayes's review of ISPs was representative. Her findings are supported by other evidence and reflect Mr. Rodman's conclusions. The testimony of Ms. Sandstrum and Ms. Whittington, discussed below, did nothing to impart confidence in the Department's ability to identify needs.

Based on her review, Ms. Hayes concluded that the system is not meeting the requirements of paragraph 32(b) because there is lack of flexibility to adapt to a client's changing needs over time. *See* Pls.' Ex. 78, p. 2, 3A-3C. She found no compliance with paragraph 58 based on

timeliness of reviews and the failure to make changes based on substantial needs. With regard to the 90-day review requirement, she determined that "late meant late" and considered any review beyond 90 days as late. The court agrees with that interpretation. For all of the ISPs reviewed, 31% were reviewed after the 90-day deadline. For the 108 ISPs, 25% were reviewed after that deadline. ¶ 58.

Ms. Hayes considers a good service plan to be one that requires getting to know the person, doing an assessment, and discussing the person's needs, strengths, and abilities. The person's long-term goals should be set by the person. The Department's training manual urges the workers to write goals in the client's own words. Although the materials provide that the ISP is client driven, her review revealed that the caseworker frequently drove the plan. That conclusion is supported by the credible testimony from class members.

During interviews, she determined that some clients were involved in the plans and for some, the plan reflected the caseworker's preferences. In the ISP, objectives are the steps leading to the goal and include a time frame and a designation of tasks. The goals are achieved through case management monitoring. If the goals are not achieved, the objectives should be revised or rewritten. The entire plan can be revised annually but monitoring should occur monthly.

With regard to paragraphs 61, 62, and 63, Ms. Hayes concluded that goals are set but they are not measurable or understandable. *See* Pls.' Ex. 78, p. 2, Construction of Goals and Action Plans, # 2. She determined that the Department has set up a system that addresses various goal areas and available services but does not address actual needs and has difficulty actually identifying unmet needs when services were not at all available and then setting up an interim plan. The Department has set up a system to reflect fourteen goal areas but the system failed in its ability to write achievable goals. The action steps were not consistently clear and were not always measurable. The goal rate for full achievement was less than 50%, which is not a positive outcome. Further, there were obvious variations in practices among regions and agencies and even caseworkers, which is a training issue.

***30** Ms. Hayes found a lack of written service agreements and actual identification of the service provider and the provider's performance expectations in the ISP, as required by paragraphs 68 and 69. *See* Pls.' Ex. 78, p. 1, # 9 & 9A. Ms. Hayes did not address paragraphs 64, 65, or 66.

Sharon Sandstrum works in the Department's Office of QI. She has been the quality improvement manager since April, 2002. Previously, she was a CDC for Region II for six years. She was among the first group of CDCs. *See* Jt. Ex. 24, p. 69647 (CDC job description in place in 1998). She continues to attend the CDC meeting as part of the QI team. She attends the quarterly contract review meetings for agencies for which she serves as a liaison if there are problems with that agency. If there are no problems with the agencies, she does not attend.

The CDCs function as groups, have cross training, and participate in ISP training. The CDCs meet at least every other week regionally and attend other meetings.

Since 1996, when the defendants were found in contempt, the Department has made efforts to locate and assess class members. The Department contracted with the Behavioral Health Network to locate class members and prepare an assessment of class members. That did not happen as quickly as the Department had hoped and additional efforts were necessary. It was apparent that "hundreds and hundreds" of class members were not being found and assessed. The Department sought additional funds for this task and received the funds.

The Department began to develop databases as a result of what Ms. Sandstrum described as "tremendous efforts" to locate class members, efforts that began six years after the Consent Decree was signed. The Department used information from DHS, the Department of Motor Vehicles, the Department of Corrections and other sources of legal information. They found class members living "under tarps in apple orchards." Fewer than 200 class members could not be found.

Efforts to locate class members continue. *See* Jt. Ex. 24, pp. 69704-69705. Although the Department had, at the time of her testimony, designated a location person, there is always a list of class members with unverified addresses. *See* Jt. Ex. 35. Currently, there are fewer than 300 class members who have unverified addresses. The Department has used the Social Security index, the ISPs, websites, and county jails' inmate lists to find addresses. County jail lists are used to locate class members and can be used to alert an ICM if a class member is in jail. For class members not engaged in case management services, the Department sends a quarterly letter regarding available services and the method to contact the CDCs and includes postcards for changes of address. *See* Defs.' Ex. 137. These letters are not sent to the class members receiving service.

The maximum number of class members totaled approximately 4,500. As of 10/02, deceased class members totaled 712 and the number of class members in service totaled 1,442. *See* Jt. Ex. 35. Approximately 559 class members currently reside out of state.

***31** According to Ms. Sandstrum, the Department becomes aware of class members who want services from the class members themselves, families, agencies, and

others. The CDCs have contact with class members who do not receive CSW services. *See* Jt. Ex. 25, p. 67951. She alleged that, to her knowledge, there are no class members not receiving community support services who want those services. On cross-examination, she was shown the results of two surveys that showed the percentage of class members who wanted services and were not receiving them. *See* Jt. Ex. 22, p. 21 (4/02). Ms. Sandstrum replied that the surveys are anonymous so the CDCs cannot do anything about the issue, even though the CDCs receive the information. She said that the CDCs have a procedure in place for people who want a CSW; the CDCs have not done anything else and have not developed any additional processes. She does not interpret that data as meaning things are not working. Her testimony on this issue is contradicted by the testimony of other witnesses, including the defendants' witnesses, and is rejected. ¶¶ 49-50, 55-56.

The defendant's December, 2001 report reveals that during the fall, 2001, when the defendants were deciding to file a notice of substantial compliance, there were class members waiting for a CSW. *See* Pls.' Ex. 89; ¶¶ 49-50, 55-56. As of October, 2002, class members continued to wait for a CSW. *See* Defs.' Ex. 66 (waiting list data). The time period for assignment of a CSW far exceeded the Consent Decree requirement. *See id.* As noted, even as of 12/31/01, the defendants claimed only partial compliance with paragraphs 55 and 56.

Some class members request that they have no contact with the Department. *See* Jt. Ex. 24, p. 69703. The CDC is required to ask if a class member has needs he wants considered and why the class member does not want contact. The requests for no contact are referred to the Court Master for a decision. She could not remember the Court Master ever denying a request for no contact. If the Court Master approves the request, that class member is removed from the quarterly mailing. The class member can change his mind and apply for services.

As a CDC, she was a liaison for training for a number of agencies in her Region, which had eight offices. Ms. Sandstrum testified that she ensured that the ISPs are filed in her office in a timely fashion. She then agreed that a CDC would not know if the first ISP for a client had been done in a timely manner because nothing is done to inform the CDC when a person is engaged in services. The ISP itself shows the CDCs that someone is now in service. It was exactly this type of testimony that compelled the court to conclude that the defendants' witnesses were describing theory and not reality.

She instructed agencies that an ISP must be developed within the 30-day time frame because of licensing requirements and the Consent Decree requirements. This requirement is part of the Department's contracts with the agencies. If the agency does not develop an ISP for a class member who requested an ISP, she said that she would have been aware of that omission because the CDC receives all ISPs that are completed. She then agreed that she would have been aware that a class member wanted an ISP only if the referral came from her office. If the referral did not come from her office, she would not know if an agency had not developed an ISP for a class member who wanted one.

***32** After development of the CMA in 1997, the CDCs began to type notes of phone calls directly into the CMA. The CDC office has an 800 number but class members can get individual numbers so they can bypass that switch board. Contact with a class member, in person or by mail, is expected to be entered into the CMA.

The procedure provides that when the ISPs arrive at the CDC office, the data entry staff is expected to enter the information into the CMA. The CMA tracks the date the ISP is received and the ISP is completed within the agency. The CMA can generate reports to agencies and flag overdue ISPs and is programmed to gather information for the case management system. Each part of the ISP is a data element. When technical problems occur, such as goals that are not attached to the ISP, the data can not be entered into the CMA. The data entry staff will fill out a form about the problem ISPs. There are always problem ISPs in the system that require attention.

The CMA prints out an ISP that is one or more days overdue. These are faxed on the first of each month to the agency from the CDCs. The report is run again fifteen days later. If any ISPs remain overdue, the report is sent to the mental health team leader, who is expected to address the problem with the agency. The CDCs developed this protocol. *See* Jt. Ex. 24, p. 69671.

Ms. Sandstrum participated in the quality review for the goal tracking study developed in 12/01, discussed above. She testified that as of 1/02, she did not find unmet needs buried in the goals. *See* Jt. Ex. 22, p. 73627. That conclusion also is rejected.

The CDCs perform a random review of ISPs. *See* Jt. Ex. 24, p. 69658. The CDCs meet with the case managers and their supervisors. The form previously used has been revised although she did not recall when the revisions were made. *See* Jt. Ex. 24, p. 69659 (undated); Jt. Ex. 23, p. 49A (undated). Changes to the form were made based on feedback from the CDCs; the previous version was not effective. The form for natural support/community services was revised to determine whether service agreements are required so that reviewers would know that if no services agreements are attached, it did not necessarily mean that the CSWs had forgotten to attach the agreements. *See* Jt. Ex. 23, p. 49D. Although Ms. Sandstrum stated that all regions now review ten ISPs, she did not know if that change occurred before 1/02. She did

not know the percentage of ISPs reviewed per month and she did not know who would know that figure. Ms. Sandstrum agreed that the CDCs do not review other CDCs' work to determine whether they are using the same procedures. The differences in the regional numbers clearly suggest that the CDCs are not using the same review procedure.

A plan of correction is expected to be issued for deficiencies. *See* Jt. Ex. 25, p. 67934. The supervisor signs off with the CDC and the supervisor works with the CSW. This information is entered on the ISP document review database. The data are sent to the MHQI team and the CDCs quarterly.

***33** Any class member can terminate services. The agency fills out the request and sends it to the CDCs. *See* Jt. Ex. 24, p. 69651. The request is reviewed in conjunction with the ISP to determine whether termination makes sense. There is no written standard for a CDC's determination to approve a request to terminate services. *See* Jt. Ex. 25, p. 67997. The determination is made based on the ISP, notes, documents, and by calling the agency and the CSW. Contacting the class member occurs less regularly; Ms. Sandstrum did not feel that such contact was required. She agreed that she had terminated service against a client's will. She does not always follow up with the agency to which a client had been referred in a termination situation. She does not follow up in each case, even if the client was reluctant about the termination.

In spite of this practice, she stated that the CDC may not be aware of a termination of services. When asked whether the formal approval or disapproval of the termination was sent to the CDC, she said she could not recall receiving many terminations. Claire Harrison receives requests for termination of services for community residential services, residential treatment facilities, and supported housing, but not for transitional facilities.

Because a group residential setting provides a higher level of support and service coordination, Ms. Sandstrum would approve a termination of other services with a CSW if a client were entering a residential setting. She did not think that all residential settings offer case management services but she would approve the termination of services because the person would get the care needed and the residential facility would coordinate services. No document or policy provides that this procedure is adequate; she bases this practice on her knowledge of services.

According to Ms. Sandstrum, the Department is able to assess whether unmet needs are being met because class members call when needs are not being met and they call other agencies as well, such as the DRC. The Department's expectation that class members will self-monitor the Consent Decree requirements should be reexamined. She stated that the CDCs sometimes can address a particular need but overall goals are achieved through the ISP process. It is true that overall goals should be achieved through the ISP process. Ms. Sandstrum's suggestion that that occurs is contrary to the evidence presented.

Ms. Sandstrum reviews unmet needs on a quarterly basis. *See* Pls.' Exs. 28, 29. The CMA cannot print a report for unmet needs by date. *See* Pls.' Ex. 28. She reviews each report for class members receiving services from her agencies. According to Ms. Sandstrum, some are not unmet needs, so she designates them not true unmet needs. For example, a person who wants a house on the lake does not have an unmet need. But that may appear in the report as an unmet need. After she reviews the ISP, she calls the agency, the class member, and sometimes the CSW. The CDCs share unresolved, unmet needs reports quarterly with the mental health team leaders and the office of QI.

***34** If an unmet need is identified in the ISP, a check is done during the ISP document review to determine whether a request was made for an interim plan to meet the need temporarily. Wrap-around funds are another source of information about whether unmet needs are addressed by the system.

Ms. Sandstrum believed that, in spite of the name of the list, some of these individuals on the "Unresolved Unmet Needs Report for Class Members" were not class members and they are served by ICMs. *See* Pls.' Ex. 29. This list was a "snapshot in time" and everyone on the "Resolved Unmet Needs Report for Class Members" had been listed on the "unresolved needs" list at some point. She testified that the "unresolved needs" list was not long because if a need can be met, it is not listed. This testimony and procedure did not make sense.

Several class member surveys are conducted. These surveys can be anonymous, but if the class members wants services, the class member has the opportunity to write his name and telephone number. *See* Jt. Ex. 25, pp. 67949-50 (class member provider survey). This information is sent to the office of QI for tabulation and is part of the QI packet. The class member community interview is conducted when the class members are living in the community. This survey is done regardless of whether a class members has an ISP. The survey is conducted annually and class members are selected at random. *See* Defs.' Ex. 69a-e. The class member provider survey data pertain to each class member that an agency is serving. *See* Defs.' Ex. 72a-d. The class member interviews at the hospital are done annually and a sample of class members are surveyed. *See* Jt. Ex. 70a-d. An ISP consumer interview is conducted for all who receive ISP

services; this is not a random survey. *See* Jt. Ex. 71a-c. Ms. Sandstrum did not know if this survey involved only class members but it did involve only people who have an ISP. This survey is done twice a year. The results are tabulated by the office of QI and fed into the QI system. The information is seen by the CDCs at the CDC meetings. Defendants' exhibit 69a, page 11 is follow up.

Ms. Whittington is the CDC for the Department's Region II office. She has had this job since May, 1996. Her job includes primary ISP training for Region II, liaison to agencies with current contracts with Community Support Services, responsibility for MHWs and consumers' concerns regarding service, QA with community agencies the Department has contracts with, and supervision of two data entry people in the office.

She trains the CSWs, who provide support for persons in the community regarding services that the people need or want. Case management involves managing the case and oversight of services provided to the individual. The CSWs are expected to do both jobs. An ICM spends more time with a client and deals with people leaving the hospital, jail, prison, and shelters. The ICMs provide a higher level of support. The CSWs, the ICMs, and the ACT Teams develop ISPs.

***35** According to Ms. Whittington's description of the process, in developing the ISP, the consumer should state what he wants and the case manager should try to make that want manageable. Action steps are developed for a goal after considering personal strengths, resources, and barriers. The action steps include what will be done to reach the goal and include the who, what, where, and when. Action steps have time-frames. The resource column incorporates natural supports with generic resources, which are resources available to the general public, including a psychiatrist, social clubs, and the YMCA. Although she testified that the CSWs did well in including generic resources and natural supports, she had no data to support that view.

The ISP training manual was revised and implemented in 1/00. *See* Jt. Ex. 23. The manual was revised again in 10/02 but has not yet been implemented and will not be implemented until the current trial is completed. *See* Defs.' Ex. 41. Changes were made in the revised manual. *See* Defs.' Ex. 41, pp. 6, # 6, 7, 9, 19, 32-33, 37.

The ISPs are expected to be as consumer-centered as possible and are designed to meet the goals of psycho-social rehabilitation. *See* Jt. Ex. 23, pp. 4-5. The ISP is intended to be a collaborative process between the case manager and the consumer; they are supposed to enter a contract together. *See id.,* p. 9 (step-by-step guide to ISP); pp. 10-11 (goal areas to be assessed); p. 17 (ISP study guide); p. 21 (outreach). With regard to consumer input, however, she stated that consumers are not as interested in the ISP as the workers. The class member has the right to grieve an ISP or any part of the process, but Ms. Whittington thought that action would be contrary to the theme of a collaborative effort. *See* Defs.' Ex. 41, p. 22; ¶¶ 57, 65. Ms. Whittington did not know if the client would be notified again about the right to appeal if an ISP is changed or reassessed.

The process requires that all goals are to be assessed initially and every ninety days thereafter. The CSW and the consumer are expected to decide what will be included as part of the ISP. If a consumer chooses not to address a particular need, that may be noted in the ISP.

If outside services are part of the ISP, a service contract is required. *See* Jt. Ex. 23, p. 43. According to Ms. Whittington, if the CSW works for a large agency and the consumer receives services from that agency, a service agreement form is not required. A service agreement is required for class member ISP services that are licensed or funded by the Department. *See* Defs.' Ex. 41, p. 9. The CDCs and counsel made this determination. Paragraph 69 provides, however, that a service agreement is required if services will be delivered by an agency funded or licensed by the State. The Department's practice is, therefore, contrary to the Consent Decree requirements.

After the action steps are documented, services and resources are to be identified. The CSWs' role is to link the consumer to needed services, to organize the services, and to advocate for the consumer. Ms. Whittington testified that this role is supposed to be consistent for class members and non-class members. The evidence in this case makes clear that that consistency is lacking.

***36** The ISP and case notes are expected to be updated for met and unmet goals, if something is no longer a goal, or the date for the goal has been extended. If a consumer chooses not to address goals, they are closed. Substance abuse, trauma, legal, and financial issues fall into the category of areas a consumer may not want to address at a particular time. The ISP is intended to be an evolving tool; goals can be added or closed at any time. All participants sign off on the ISP. *See id.,* p. 25; *see also id.,* p. 13 (risk benefit statement). The ISP can be renegotiated at any time.

If a client does not want a CSW involved, a goal will not be on the ISP because the ISP is supposed to be the joint effort of the client and the CSW. If the goal involves the client and any other agency, that goal also would not be on the ISP if the consumer chooses to do the work without the CSW. If a consumer does not need a CSW's help but otherwise wants services, that also is not listed on the ISP.

A concise summary of what happens with goals is required to permit an accurate review. *See* Defs.' Ex. 41,

p. 11. Ms. Whittington stated that a "dissolved" goal is a goal that can no longer be followed, such as a goal to take a daily walk but the client breaks her leg. *See id.,* p. 18. If a class member cannot find services to meet needs to achieve a goal, "dissolved" would not be appropriate, according to Ms. Whittington. "Goal achieved" means that a goal was actually achieved. If a client does not want to pursue a goal, the notation is "CC," which means that the client chose not to address the goal. The ISP training materials do not, however, support that interpretation. *See* Defs.' Ex. 42, p. 4.

Ms. Whittington described unmet needs are needs that can not be met by existing resources, versus unmet wants, such as a new car. *See id.,* p. 14. Unmet needs are to be documented on the summary sheet. An interim plan to meet the need should be developed, which can include calling the CDC office or using wrap-around funds. The determination of whether a goal has been achieved is based on the case managers' clinical assessment. Ms. Whittington testimony that goals use to "disappear" but that no longer happens is not supported by the evidence.

Goals should not be open for more than one year in order to permit tracking of progress. *See id.,* p. 9. For example, remaining on medication is a life-long goal but that goal could be fine-tuned to suggest that the person will stay on medication with only one prompt each day. That procedure allows the consumer to celebrate success more often.

The ISP should include a crisis plan, which is reviewed annually. *See id.* p.28. The evidence shows deficiencies in meeting this important requirement. The crisis plan should be developed when the consumer is doing well as opposed to during a crisis. The plan is intended to be shared with the local crisis program. Expectations regarding service providers should be listed in the service/resource section of the ISP.

***37** If a CSW is changed, the CSW and the replacement CSW are expected to meet with the consumer regarding the plan and sign the plan. If a consumer goes to a different community support agency, the ISP follows the consumer. The new agency is expected to develop a new ISP with reference to the previous ISP. The consumer has 30 days to change his mind about the new agency and a letter is sent to that effect. If he does not change his mind, the existing ISP is closed, including the services and the action steps. The new agency has 30 days to develop a new ISP. Every agency has to have its own ISP because of medicaid licensing requirements. An ISP cannot be closed until the regional office approves or disapproves the request to terminate the agency. *See id.,* pp. 32-33. Ms. Whittington was asked whether termination of services had been approved against a client's stated wishes; she replied that nothing came to mind. *See* Pls.' Ex. 27A-C (requests to discontinue service). The evidence shows that such terminations have occurred. Ms. Hayes noted this requirement that persons change or transition services. *See* Pls.' Ex. 78.

An agency can request training at anytime, including the ISP 101 course or specific training needs. *See* Defs.' Ex. 42 (ISP 101 training in effect 1/01 except for the letter dated 4/9/02); Defs.' Ex. 43. Document review training is given to all CSWs in order to assess the quality of work. The CSWs take one of their ISPs to the review and that ISP is reviewed. The CDCs also conduct training at agencies on the ISP process.

Ms. Whittington stated that there has been improvement over time in the quality of ISPs although they are not perfect. The CSWs were overwhelmed at first with regard to the amount of paper but she stated that they understand now that the process should drive the forms and not the other way around. She testified that training on measurability of goals is now better. When asked whether that was a problem, she replied that CSWs continue to need training and support for what they do. When asked again whether the data reflected a problem in this area, she was responded "I am not sure that I am qualified to say." It is an ongoing training issue and a continued area of discussion.

The CDCs have contact with the CSWs and perform a quarterly quality assurance check of randomly selected ISPs. All ISPs and reviews go to Ms. Whittington's office. Technical errors are brought to her for resolution. She is a liaison CDC for approximately 200 to 250 class members in the agency she serves. She also receives calls from CSWs with questions about ISP the process.

A person is entitled to assignment of a CSW within three working days of a referral. If she cannot meet that deadline, she notifies the Intensive Case Management program to obtain interim caseworkers. *See* Jt. Ex. 28. Every ISP for class members in her Region is expected to be sent to her office within 30 days after the due date. She could not remember specific statistics regarding the timeliness of submissions. She did not know the percentage of timely completions.

***38** An ISP is to be entered in the CMA within ten days of arrival at the CDC office. Reports are generated quarterly and reviewed. Based on that timeline, she agreed that possibly a CDC would not review for four months a need listed on an ISP. She testified that that did not mean that work would not be done because the CSW would "probably call." She agreed, however, that it was not in the training manual to call a CDC regarding unmet needs.

Ms. Whittington declined to say that an inadequate ISP has an ill effect on a consumer. She maintained that an inadequate ISP does not mean that the services are not

good; it means, instead, that the documentation may not be as good as it should be. She maintained that an ISP that does not include issues a class member wants addressed and an ISP that is not submitted by the CSW in a timely fashion do not mean that the need would not be addressed. The need may not be on the ISP but the ISP is only "some evidence." She would speak to the consumer and would review the ISP with the CSW. When quality assurance is done, however, the customer is not present. The review includes only documents and the CSW.

Her conclusions on this issue are contrary to her own testimony that the ISP is the foundation to all treatment planning for adults with mental illness and are rejected. The failure of documentation and not the failure to provide services was a consistent theme for this witness. For example, when shown the data in the ISP document review summary regarding accessing generic and natural supports, she was not surprised at the low percentages because possibly it was a "documentation problem." *See* Jt. Ex. 22, 4/25/02 Memo.

She was asked whether there were any problems with the data from ISP reviews. She said there were areas for improvement based on numbers in the charts and discussions at CDC meetings. *See* Jt. Ex. 22. The CDCs review unmet needs. The unmet needs are identified by the agencies and are reviewed by CDCs to determine if they are true unmet needs. Plaintiffs' exhibit 28 shows unmet needs reported resolved. Plaintiffs' exhibit 29 shows unmet needs reported unresolved. These reports are generated by the case managers. She did not know if anyone had checked with the client before determining that a need is met; there is no note to that effect *See* Pls.' Ex. 28, pp. 3, 7. The CDC decides with the CSW if an unmet need is resolved. The people listed on the unmet needs resolved report no longer have "a documented unmet need," based on the decision of the CDC and CSW. This assessment of unresolved unmet needs is forwarded to the resource development office and is expected to be considered in the budget. *See* Pls. Ex. 1, Pls.' Ex. 29.

The majority of unmet needs are based only on ISPs and, in general, the CMA has data on ISP information. There is an unmet needs field in the CMA for people who do not have an ISP but Ms. Whittington did not recall if she ever used it.

***39** Needs of class members not in service are not documented in the unmet needs report. This information is in the contracts of agencies reporting the number of people requesting case management services and is documented in the activity log section of the CMA. When she received calls from people who want CSWs and ISPs, she would meet urgent needs directly from the office, such as needing heating oil, and then refers the person to an agency in the area of their residence. According to Ms. Whittington, this information would not be on an unmet need list because the need is not unmet.

She participates in the regional QI team and attended the 2/8/02 meeting. *See* Jt. Ex. 22, pp. 73672-73683. This document speaks for itself. The court notes particularly the conclusions that there is inadequate data to monitor the quality of the system for non-class members and that the CDC data and performance indicator data do not support each other regarding waiting list data. *See id .,* p. 73682. When she testified in October, 2002, Ms. Whittington noted, "we have a good start on it."

Linda Pellegrini is the Director of Community Support Services for the Kennebec Valley Mental Health Center. Her job responsibilities include three separate service areas: (1) twenty-seven CSWs; (2) the High Hopes Club House with one director and six CSWs; and (3) a twenty-four/seven residential program with two house managers and fourteen full-time staff. The High Hopes Club House is designed to simulate the work day and is very member-oriented. The clients are taught vocational skills so that they can get a job. She did not know the number of class members in the High Hopes program, but it was a "fair number." There are 200 lifetime members. Almost all of the people in supported living are class members.

Kennebec Valley has laid off nine people, including seven support staff and two clinical positions. They discussed with the Department the reductions that were going to have to be made. Although they are not currently discussing restricting services, medical necessity will be an issue. The services that they deliver will have to meet some standard of medical necessity; they will have to be able to document that the services are medically necessary. The issue now is how to deliver services in light of that requirement. She did not know whether this requirement would affect services under an ISP.

The CSWs she supervises try to help clients meet their basic needs, including housing, food, clothing, and vocational rehabilitation. She has 450 clients, 132 of whom are class members; there are six CSWs on her team. The clients do not attend team meetings.

Clients are to be notified about the RRMHS. A discussion of grievance rights is included a book available to clients. ¶ 57. Information about family support services and about getting involved with the National Alliance for the Mentally Ill (NAMI) is available.

Kennebec Valley is a member of the Kennebec/Somerset group and individuals are referred to that group. If class members or non-class members want only a CSW, Kennebec Valley refers the person somewhere else, including the Kennebec/Somerset service provider group. If the person wants medicine and community support, Kennebec Valley can do an intake because the person

wants services from Kennebec Valley Mental Health Center. No one follows up to see if a client referred to another agency actually made it to that agency.

***40** Kennebec Valley does the required full psycho-social assessments in Augusta and HealthReach does them in Skowhegan and Waterville. There are uniform requirements for eligibility for Kennebec Valley's services. The requirements for eligibility for services include being eighteen years of age or emancipated, an Axis I diagnosis, ruling out just substance abuse, class member status, a recent discharge from AMHI or an acute psychiatric unit, homeless status, a Department-funded placement, a history of psychiatric hospitalizations, or people taking certain medicines. Class members, however, are eligible even with no diagnosis of major mental illness or personality disorder.

With regard to intake, class members have priority coming out of the hospital. They are expected to be assigned an interim social worker within two days after discharge from the hospital and within three days if they are referred from the community. She did not know the time frame for assignment of a worker for non-class members. The interim case manager does an assessment. If they have openings they call Lauren Ross, who works with the consortium, to find out who is next available on the priority list. They attempt to distribute clients fairly among the agencies in the consortium.

The expected procedure provides that a client questionnaire, releases, and a seven-page assessment are in the file before the ISP is developed during the thirty-day period. All contacts with clients should be listed in the progress notes. An RN reviews the charts monthly and gives written feedback with regard to deficiencies or areas to improve in ISPs. Ms. Pellegrini also reviews ISPs after the CSW discusses the ISP with the client. If a deficiency is found, Ms. Pellegrini returns the ISP to the CSW.

Most CSWs have a MHRT-II provisional license. The CSW can be hired with that license but is required to take the remaining required courses. The CSWs should receive an orientation to the agency and community and at least twenty hours per year of training in ethics, substance abuse, trauma, and issues specific to the Consent Decree, including the topics listed in paragraph 70. The CSWs shadow another CSW during the first three months of training. Specific training is done in groups and in-service training is held. The CSWs have a full case load after three months.

The ISP process is "a constant challenge," especially regarding whether action steps are measurable and attainable. Ms. Pellegrini agreed that the CSWs do not always participate at the hospital discharge meetings and do not always develop an ISP within thirty days. She observed that the CSWs, who have "the least education in the system," are asked to do "technical things." There are no educational requirements for CSWs except for the requirement of a MHRT and certified courses, which can be waived based on experience. A high school diploma is not required for CSWs. The CSWs have to meet the requirements listed in defendants' exhibit 58, which is dated August, 2002. *See* Defs.' Ex. 58. MHRT certification requirements existed prior to August, 2002 and were "similar" to these; she did not know if there were differences. She initially stated on cross-examination that her workers did not have training in perspectives and values and consumers of mental health services although that answer changed on redirect examination.

***41** In July, 2002, the CSWs received a $2.00 per hour raise; they now earn $14.00 per hour on average. Kennebec Valley had been unable to hire CSWs because of salary restrictions.

Ms. Pellegrini described their policy. Service agreements for outside services are to be done for class members. Class members are asked if they want services provided by the Kennebec Valley Mental Health Center or another agency. If the client chooses another agency, a note is made for any contact. The CSW monitors provision of services on the ISP; if the services are provided by another agency, the CSW monitors the services as much as the client will allow. On occasion, the CSW will meet with another service provider. Part of the CSW role is advocacy for the client. The CSW can achieve more if the client's services are provided by an agency funded by the Department.

Reviews of ISPs by CDCs are done randomly. She attends only if the review involves one of her CSWs. They review one chart She could not remember the last time that occurred. Ms. Pellegrini had the ISP document training in October, 2002.

With regard to quarterly reviews and updating of ISPs, she stated that they now have great hopes for the computer system to trigger dates for updates for the ISP and for eligibilities so that Medicaid will pay for services. If the ISP is not updated, the service cannot be provided. The CSW remain responsible, even if the computer malfunctions.

Kim Lane has been the Director of community services for HealthReach Network for six years. HealthReach has four programs: ACT, case management, employee assistance, and nursing. The ACT Team program began in 1995. It includes a team of psychiatrists, an RN certified in mental health, a senior case manager with more than five years experience, and four case managers. Their program differs from the national model because the national model also includes a vocational counselor and a

substance abuse counselor.

The ACT Team has forty-seven clients; thirty-nine are class members. Generally, the ratio of class members is higher but never reaches 100%. The team received four new clients in September, 2002. A few clients have family supports and a few have guardians. The ACT Team has a contract with the State to provide services to clients, including medicine, medical services from the nurse, and delivery of medicine, sometimes daily, weekly, or monthly. The ACT Team stores medicines so the clients do not have to have the medicine at home. The ACT Team helps the homeless with housing and obtaining resources.

Ms. Lane described the ACT Team's process. The ACT Team differs from a CSW because the Team sees the clients more often. The Team has a twenty-four hour/seven day per week emergency room service, does direct admissions to hospitals, works with the crisis team to do assessments, and provides respite care beds. There are residential care units in Augusta, Waterville, and Skowhegan for clients who need stabilization.

***42** If the clients need crisis services, the case manager does a crisis assessment and calls crisis to see if a bed is available. If not, in-home supports or family member supports are relied upon.

With regard to eligibility for the ACT Team, most clients have numerous hospitalizations and failed attempts to medicate themselves. These clients have failed to make appointments, do not follow through with community treatment, do not stay in their home or apartment, and are homeless when the ACT Team receives the client. Many clients have not had required physical attention, including dental work. A high percentage use substances; eighty-three percent of the forty-seven clients have a substance abuse diagnosis. This ACT Team receives clients from AMHI, the Kennebec/Somerset provider group, the ICMs from Region II, and the Lewiston ACT Team.

The level of care required determines eligibility, not class membership. The team was at capacity at the time of Ms. Lane's testimony; if a class member applied, that person would be wait-listed. The level of care required determines who is accepted from the wait list as well. The wait time can last from three to four months. She did not know the wait list time period in January, 2002. There always are people on the wait list.

The treatment teams decide whom to accept. The team does not accept all referrals. The ACT Team does direct admissions to certain hospitals and involuntary admissions as well.

The procedure provides that a psychiatrist meets with the clients when necessary. The team leader is a LCSW who does therapy. The senior case manager is expected to oversee the program, make sure the clients are seen regularly, and coordinate the daily functions of the case managers. Each morning, the team meets to decide where the members will go. All case managers have a core group of clients assigned to them, mostly for paper work purposes to maintain charts, but all the clients know all of the members of the team. Case managers want to know everyone when they are on call, because they rotate the after hours on-call duty, from 5 p.m. to 8 a.m.

After hours, the first person on call is the senior case manager, the second is a Masters level position, and the third is a psychiatrist. If a client meets the criteria for crisis services, the case manager handles that situation. If the client requires admission to the hospital, a psychiatrist can handle that situation by telephone if the client has been seen within forty-eight hours. During the day, the team will do blue papers or involuntary admissions. At night, if an admission is involuntary, the client goes to the emergency room. The team does not reject a patient if there is an opening; if there is no bed, in-home support must be done. Emergency in-home support is done by an organization called Richardson Hollow. The treatment team and the client decide the number of hours of in-home support necessary.

The ACT Team clients receive outside services only for substance abuse and counseling. After referral to the team by the case manager, the psychiatrist and the team leader meet with the client. If the client agrees, a team meeting is scheduled to develop a treatment plan ISP. The client consents to treatment and understands the RRMHS. She attended five treatment team meetings during the last year. She has attended the CDC ISP review. The meetings that she attended were not attended by case managers.

***43** The usual goals for the ACT Team clients are housing, medicine, treatment, dental care, vocational, and crisis. The clients cannot pick and choose services; the ACT Team clients receive the ACT Team services. The biggest challenge is transportation. All should have a crisis plan as part of their ISP. Immediate emergency services may not be put on the ISP. The individual case managers are expected to update the ISPs and send them to the Regional II Office. The staff of the ACT Team goes through the random ISP review by the CDCs. All of the ACT Team staff go through all of the trainings.

Seven or eight clients have been with the ACT Team since the beginning and will not be transitioning soon. Some transition to the case management program. Sometimes the staff has daily contact with clients, especially because the ACT Team has the clients' medicine.

Debra LaPointe is a Senior Case Manager at HealthReach

Network. The case management part of her job involves linking people to resources and the community support part of her job involves outreach, helping people to move toward independence without feeling abandoned. Her clients require both of these types of services. She has a MHRT-II, a requirement for a CSW. She also has an LSW conditional. She received ISP 101 training one year ago. She has not received ISP document training.

Her caseload includes fourteen people, six of whom are class members. She has had seventeen clients within the year before her testimony; the usual is sixteen. Approximately one-third to one-half of her total clients are class members.

She described her procedures. When she receives a referral, she contacts the client and schedules a meeting. She tries to meet the clients needs within seventy-two hours but the meeting may not happen for a few months. She explains case management to the client and what the team can offer. She develops a preliminary ISP and works on a psycho-social assessment. This has to done within thirty days but she does not always meet this deadline either.

The psycho-social assessment is a separate document from the ISP. She coordinates with other agencies with regard to what the client will accept. If the client does not want Ms. LaPointe's involvement, she monitors the client. If the client wants her involvement, she meets with the client and advocates for the client.

In developing the ISPs, she and the client work on goals and prioritize those goals. She does outreach goals for one month. She meets with the client on the psycho-social assessment in order for the client to get know her. Initially, the client may not want to participate in a goal, but that goal is a reminder to them to continue to determine whether the client wants to pursue something in that goal area.

She and the client identify the goals and the steps needed to achieve the goals, including identifying the things that stand in the way of achieving the goals and the resources available to achieve the goals. Some of the resources needed for goals are already known by the case manager and the client; information is gathered on other goals. The license requires that the case manager play some part in the goals, even if the case manager only monitors them.

***44** She prepares progress notes when she has contact with clients. During 2002, she has worked on housing and obtaining licenses, bus passes, fuel assistance, Medicaid applications, and Social Security applications. Most goals are intended to increase the quality of life. The resources that are most difficult to obtain include transportation, financial aid, education, and vocational rehabilitation. One client has been waiting for a vocational rehabilitation appointment since July, 2002. His appointment was November 15, 2002.

The client determines priorities and the achievement date on an ISP. It is not possible to determine from the ISP which goal is most important to the client. Typically, the period for attaining a goal is not more than one year. If a client feels he does not want to address a goal, the designation "CC" is indicated. If a goal is not achieved by the end of the year, the goal will be dissolved and rewritten so that it is more attainable. The term "dissolved" is also used for a goal if the person leaves services or transfers and will not continue his ISP with HealthReach Network.

The CDCs meet with her to review the ISPs. The last meeting occurred in October, 2002. One ISP was reviewed and the client was not present. There was no plan of correction. The last CDC review was held in September, 2002; she thought the reviews were held every three to six months.

As the client becomes more independent, Ms. LaPointe will be less involved. The client reports his progress and if things are not going well. Sometimes the client can advocate for himself and sometimes the resource needs to be changed. If she is unable to find a resource to achieve a goal, she tries to access wrap-around funds. If there are no resources and no funds, they apparently wait to see what will happen because the goal is there. If nothing does happen, an interim plan can be developed but everyone knows that is not the ultimate goal.

She agreed that at times she has problems with agencies. Service agreements are not returned and she has not been diligent in pursuing the agreements. She does not use the service agreement forms. Her supervisor told her during 2002 that she could be more diligent.

Intensive Case Management

Harold Haines has been an ICM in Region III since 1996. Region III has ten ICMs The Intensive Case Management program provides outreach for people resistant to services. He has no caseload besides outreach. He connects with people, visits the shelters a couple of times a day, tries to get people Medicaid and medicine, builds relationships, and takes people to general assistance. He describes his job as "more crisis type work" for people who will be in crisis. The biggest challenge in Region III is to do outreach for pre-crisis people and to build trust to encourage clients to consider getting the help they need.

Accessing available psychiatric services has been difficult in the past. Recently, in the last couple of years, the wait to see a psychiatrist is one or two weeks, assuming the client has Medicaid and everything is arranged. The wait

for a medicine management process can be two weeks or longer.

***45** He does not develop ISPs for clients because they have a short-term situation. He considers his role as working with those resistant to treatment and then becoming part of their ISP support.

Mr. Haines discussed some of the class members he has worked with. *See* Defs.' Ex. 84. Client # 1 had been on Mr. Haines's caseload for three and one-half or four years before his testimony. He met this client in a shelter when he was quite psychotic. The client had legal issues in several counties and had been hospitalized three or four times at AMHI, BMHI and Togus. This client would not accept services for a long period of time but is now a client with the Nutter Agency and Mr. Haines is part of the ISP support.

Client # 2 had been working with Mr. Haines for four and one-half or five years. This client was hospitalized at BMHI off and on for years, never wanted to be part of the system, and usually ended up in the legal system or in the hospital, or disappeared and surfaced in various parts of the United States. He was currently in Bangor; Mr. Haines saw the client when he is in the hospital.

Client # 3 was now with another agency. Mr. Haines was part of the ISP support.

Client # 4 was connected to services at another agency by Mr. Haines. It is hard for this client to stay connected to services.

Mr. Haines met client # 5 three weeks before his testimony. They met at the Bangor shelter through the program manager at the shelter. The client left AMHI and went to the Knox County Jail. He was in Portland and Mr. Haines called the Portland caseworker to notify him about client # 5's whereabouts.

Mr. Haines visits the Bangor area shelter most often. That shelter has a 32-person capacity and keeps annual statistics. The shelter reports that 70% of the people who use the shelter have a mental illness diagnosis.

There is a sixteen to eighteen month wait list period for Section 8 housing in Bangor. A voucher is usually available within a week but the problem is finding a place to live.

Gordon Ringrose has been an ICM in Region I for five years. His current caseload is fourteen, although several client closures are currently being done. His average caseload is ten to fourteen clients. Class members currently comprise approximately 75% of his caseload but that percentage can be lower. He has no idea how his caseload size is determined.

Region I has fourteen ICMs and an intake specialist to write the ISPs. Mr. Ringrose's practice is to meet with the client soon after assignment. He looks at the file and the ISP, which has been completed. He attends bi-weekly meetings with the team, including the Medical Director. Mr. Ringrose provides "anything under the sun" in terms of services. The biggest resource challenge for him is a client who is not on Medicaid.

He discussed former or current clients, all of whom are class members. All were at AMHI and were resistant to leaving the hospital. *See* Defs.' Ex. 85. Mr. Ringrose worked with client # 1 for three years while the client was at AMHI. Mr. Ringrose did not know why he was assigned to this client as opposed to a CSW. This client refused to speak to Mr. Ringrose; the client either asked for money or he walked away. When asked whether anyone suggested that things were not working because the client would not speak to Mr. Ringrose for a three-year period of time, Mr. Ringrose responded "no" and that for him, there "will be a better day" and that sooner or later, he and the client would connect.

***46** This client had an ISP and his goal was outreach. While this client was at AMHI, Mr. Ringrose attended 80% of this client's treatment team meetings. The client was asked to attend each of those meetings. Before the meeting, someone left to get the client, returned, and said that the client chose not to attend; that was the end of the matter. The client's failure to attend the treatment team meeting was never discussed at the meetings. No independent consultant had ever been retained for client # 1 and Mr. Ringrose had never recommended a consultant. After the lengthy stay at AMHI, Mr. Ringrose stated that this client is a "different person" now that he is out of the hospital.

Mr. Ringrose worked with clients # 1, 9 & 10 while they were at AMHI. He attended the treatment team meetings for all of these clients and the clients were always asked to attend.

Client # 2 is was assigned to Mr. Ringrose six months before his testimony and is currently on his caseload. The client already had Medicaid. She has diabetes and will require assisted housing; her goal is housing. Because the client and her brother have agreed that she will need assisted living, alternatives to assisted living have never been discussed.

Client # 3 is currently on Mr. Ringrose's caseload and has been for nine months. The client has an ISP and the goal is outreach. This client is very independent and does not want many services, although he did want dental services.

Client # 4 was on Mr. Ringrose's caseload for sixteen months. This client moved from the Maine Medical

Center emergency room to Spring Harbor to AMHI to Shalom House, a process that lasted two or three months. The client was discharged from AMHI four months before Mr. Ringrose's testimony. The client's guardian was involved and was very concerned about the client going to an apartment on his own and wanted the client in transitional housing. Mr. Ringrose did not try to suggest alternatives or dissuade them from transitional housing. Even though this client is in a two-year program at Shalom, his ISP, signed by the guardian, has no housing goal for transitional housing. Mr. Ringrose said there "probably should be one." Mr. Ringrose actually testified that after talking to plaintiffs' counsel during cross-examination, he would put a housing goal in the ISP. On redirect examination, an unsuccessful effort was made to explain this deficiency by noting that the guardian did not ask Mr. Ringrose to develop a housing goal.

Client # 6 had been on Mr. Ringrose's caseload for two years and ten months. This person needed housing, has a job at the Mall and is doing well. Mr. Ringrose obtained wrap-around funds for this client but difficulties arose because the issue was not discussed with the client before the funds were obtained. The lesson learned by Mr. Ringrose was the importance of communication.

Client # 7 was a long-term resident of AMHI who was not ready to live in the community due to mental illness. Mr. Ringrose took the client's mother to visit the client at AMHI frequently.

***47** Mr. Ringrose worked with client # 9 only during the two and one-half years she remained at AMHI. She blamed Mr. Ringrose for her guardianship, which occurred six or eight months before her discharge from AMHI, and would not speak to or deal with him. Once again, he thought the situation would change. He never recommended that this client receive a different CSW because she would not work with him. On redirect examination, this situation was defended by noting that the guardian for client # 9 did not ask for a different case manager.

The treatment team meetings for client # 9 were similar to those for client # 1. Client # 9 never attended the meetings. Someone left the meeting to get her, returned, and reported that she did not want to attend the meeting. Her failure to attend the meetings was never discussed. At the treatment team meetings after the guardianship was in place, there was no discussion about her refusal to deal with Mr. Ringrose. As with client # 1, Mr. Ringrose was unable to name any consultant who was ever asked to review this client's case during her two and one-half years at AMHI.

John Bonner has been an ICM in the Lewiston Region for six years. His caseload was eight clients but the caseload was usually higher, with eleven or twelve clients. He had three class member clients at the time of his testimony; his class member caseload ranges from zero to seven.

His Intensive Case Management services include helping with housing, probation and parole, jail, transportation, substance abuse, guardianships, dental, eye, medical, work, hospital, crisis, and moving. He said "the list goes on and on to be honest with you." In general, psychiatric services are the most difficult to access. The time clients stay with ICM program varies from one day to five years; the average is six months. Most go on to community support, prison, jail, no services, or they move. Mr. Bonner stated that there is not much the program can do for clients when they are in jail.

Mr. Bonner also discussed clients he has had; all are class members. *See* Defs.' Ex. 83. Client # 1 had been a client for three years and was assigned to Mr. Bonner by his supervisor. When a client is assigned, Mr. Bonner tries to make contact as soon as possible, usually within a day or two. If there is a guardian, he calls the guardian. This client had been at AMHI for seventeen months and wanted to move to Lewiston. The client did move to Lewiston and Mr. Bonner helped him obtain a psychiatrist, an apartment, furniture, nursing services for injections, transportation, a medical doctor, join a social club, and attend Alcoholics Anonymous. This person had a long history of not working well with agencies but things are going well. Mr. Bonner continued to speak to the client and the guardian and to help them with what was needed.

This client initially had in-home support for 56 hours per week, eight hours per day. He had changed to a system in which help was available from 9:00 a.m. until midnight; he may not require help that often. Mr. Bonner sees client # 1 once a week and receives feedback from him and the guardian. He developed an ISP for this client, which included as initial goals housing, living skills, interim support, introduction into social clubs, and going to appointments. Mr. Bonner met with the client to complete a 90-day review to update the ISP.

***48** Client # 1's situation had changed dramatically. He had had twenty admissions during the seventeen months before Mr. Bonner met him. He had no return admissions and had spent only ten days in a hospital during the last three years. This person will be assigned to an ICM for some time.

Mr. Bonner met client # 2 through Tri-County Mental Health. The client had been discharged from AMHI, had no place to live, and was living in his car. He was not taking medicine and had significant problems in the community. Mr. Bonner helped get him an apartment and furniture and reconnected the client with doctors.

They wrote a broad goal in the ISP. Client # 2 needed more goals but was unwilling at that time. He was not taking medicine and had severe substance abuse problems. He was hospitalized at AMHI from January through April, 2002. While at AMHI, he began taking his medicine and decided that he needed substance abuse treatment, that he wanted a job and to live in the community successfully, and that he wanted to see his son. He left AMHI on passes to see his family. They also applied for a payee during this period. He reconnected with a doctor and sees a substance abuse counselor at Tri-County.

Mr. Bonner stayed in touch with this client, paid his bills, and gave him money. His goals were vocational and living skills. He had been assaulted because of the way he presented himself to others. The client was working on that issue and was trying to get a job. There were no plans to discharge this client from the Intensive Case Management program.

Clients # 3 and # 4 were Mr. Bonner's former clients. Mr. Bonner had client # 3 as a client from August, 1991 through February, 2001. He had lived in a mobile home, had no water for years, and was not paying his rent. He was highly agitated, was decompensating, had a bad relationship with a woman, and problems with the law. His family was very concerned that he was going to lose the mobile home. Mr. Bonner referred him to legal services and they were able to move the mobile home and cancel the past rent debt. This client wanted a job but did not trust people and had significant social phobias. He received vocational rehabilitation but it was determined that he could not work. He worked for his family and did volunteer work at the time of Mr. Bonner's testimony.

Client # 3 transitioned out of the Intensive Case Management program. He no longer received services because he did not want them.

Tri-County referred client # 4 to Mr. Bonner and he had this client on his caseload from February, 1999 through November, 1999. He helped the client move into an apartment. He worked at a boarding home and had a car. He had a Tri-County worker and was no longer receiving Intensive Case Management services.

Mr. Bonner has had class members assigned on an interim basis because there was no CSW available. *See* Jt. Ex. 25, p. 67938. One year ago, Tri-County had a shortage of CSWs and the ICM program provided services for three to six months to three or four clients. The ICMs developed ISPs and stayed in contact with Tri-County. The ICMs had notice before the agency was able to take the client and the ICMs could provide a transitional goal period. If the client was a class member, they made sure that the class member, Tri-County, and the ICM agreed on the plan. If the client's goals had been achieved when he went to Tri-County, the goals were marked achieved; if the goals had not been achieved, they were dissolved. The defendants' practices regarding dissolution of goals was heard throughout the testimony.

***49** Because Tri-County does not have staff, if that agency is "overwhelmed" with a client's needs, the ICMs take a client on an interim basis. Mr. Bonner did not know why his program was able to pick up clients and Tri-County was not. The ICMs pick up clients even if they have maximum caseloads. He stated that he was not aware that this practice has an ill effect on the continuity of care, relationships, and ISPs. The defendants' use of interim workers because they cannot meet the Consent Decree deadlines is a consistent practice. Contrary to Mr. Bonner's conclusion, the evidence shows that this practice does have a negative impact on clients.

Mr. Bonner was asked if he received training on the requirements of the Consent Decree. He said he "would not call it training." He said that he has read the "book" and talked to people.

The CDCs review Mr. Bonner's ISPs. Eight have been reviewed. He has written three hundred.

Albert McClellan is a Region II ICM supervisor. Region II has 24 ICMs and four teams of ICMs and support specialists. He supervises Kennebec and Somerset Counties.

The teams function in similar ways and back up the other teams. His average caseload for his northern team is 35 clients. The western team has 70 clients, Augusta has 51 clients, and coastal has 51 clients. Fifty-five percent of the clients are class members. Eighty-six percent of the Augusta team clients are class members. These are class members with dangerous behaviors and with histories of problems getting services. Class members in the Augusta-Lewiston area require more services than those in other parts of Maine.

Mr. McClellan stated that the purpose of the Intensive Case Management program is to work with people who have had poor results with agencies and who do not follow up with services for a variety of reasons. He works with class members who want to address their needs. He could not estimate the length of stay of clients with ICMs.

He described the procedure. Class members are automatically eligible for the program because of their status as class members. Class members can self-refer or are referred by the Consent Decree department or by their case manager. For non-class members, there are several criteria for eligibility, including major mental illness.

Although he initially testified that there is no waiting list for class members to receive services from Intensive Case

Management program, the October, 2001 data show that there were 37 class members waiting for services. *See* Jt. Ex. 22, p. 73650. There were 260 non-class members waiting. *See id.* When asked to explain this discrepancy, he said that different resources are available and staff vacancies in agencies are a fairly constant problem.

The ICMs have more than ten people on the case management caseload from time to time. They take class members regardless of the caseload numbers if the ICMs are the last available agency. Non-class members are turned away if the program is full. The ICMs adjust caseloads by asking clients if they want to transfer.

***50** Class members are picked up by the ICMs if they have been referred to a local provider group and deadlines for services will not be met by the provider. For clients who cannot get case management services within three days, the ICMs share assignments with local service providers. The Intensive Case Management program is the failsafe. An interim worker, who is an not an ICM, is assigned to agencies and a person could be assigned an interim case manager because the Intensive Case Management program was unable to take the person.

The ICMs have frequent contact with the class members initially because the person then has multiple needs that have to be addressed. Contact later can be daily, weekly, bi-weekly or once a month.

Initial contact with the class members is within 48 to 72 hours of notice of the assignment. Class members do not remain in the Intensive Case Management program for a long period of time because they go to another agency. As soon as the needs are met, they try to link the class member with another agency and with community support. He agreed that if they refer people to a contracted Department service provider, they should get a service agreement.

The ICMs review the enrollment lists at shelters and jails for class members and to determine if they have any interest in services. The workers visit the shelters on a daily basis, especially in Augusta. They go to the Somerset jail weekly and the Kennebec jail almost daily.

The ICMs have a 30-day outreach effort; if a person needs services beyond 30 days, especially if the person is a class member, the person is asked if he wants an ISP. The person can stay with the ICM or can be referred to another agency. If the person has been with an ICM for 30 days, the person is asked if he is ready to go to a community support program. Typically, the person agrees. The ICM sends a request to terminate form for approval. The ICM tells the class member that the case will be closed within 30 days and the client referred. If the person does not want to go to a community support program, the ICM continues to work with the client. Many people, especially people who are in jail and are seen by the ICMs on an outreach basis, choose not to continue with support services when their immediate needs are met.

For after-hours assistance, class members have access to a 1-800 number. The ICMs tell clients that there is an 800 number for after hours. The ICM business cards, which have been used for sixteen months, list an incorrect 800 number.

There are two workers on duty after hours, seven days per week. If case management is needed, it is provided immediately, including fuel, food, and transportation. There is a time line to develop an ISP; if a class member will be in the ICM program for only 29 days or fewer, no ISP will be done. With regard to the client's existing ISP, goals are either closed, achieved, or dissolved. Mr. McClellan would dissolve a goal if it was a longer-range goal and had to be worked on with a CSW.

***51** Ms. Smyrski had a meeting on 1/11/02 regarding problems with timely assignments of CSWs. A policy issued several weeks later, after 1/25/02. Although she knew that the ICM caseloads were challenging, she did not review the caseloads prior to issuing the policy requiring ICMs to accept assignments in order to meet the requirements. She determined that the ICMs could handle these extra patients because, without review, she "knew" the caseloads were below the maximum ratio of 1:15 and she knew there was "a little give" in those caseloads. She said that the Department considered continuity of care in the Intensive Case Management policy but that the Department wanted the people to have the supports requested as soon as possible. She denied that this policy was intended only to show that they could document a referral in a timely way. In any event, documentation after 1/25/02 of the ability to make timely referrals is untimely.

The Department proposed to change the requirements of paragraph 69. The plaintiffs objected and the Court Master did not authorize the proposed changes. *See* Pls.' Ex. 103. The Department noted that it was its policy not to use service agreements when CSWs and other services provided to a client were from the same agency. The data submitted by the Department showed that there was a very small number of service agreements used in the system. Mr. Rodman disagreed with the Department's interpretation in a recent report to the court. The Department never requested his approval of its interpretation of paragraph 69. In spite of the plaintiffs' objections and the Court Master's opinion, the Department has proceeded with its interpretation.

Class Members and Relatives[3]

Although the defendants argue that the plaintiffs did not

select witnesses who had positive experiences with the mental health system, presumably the defendants expected their witnesses to be helpful to their cause. Certainly the message of some class members and their relatives was lost due to their anger, which, frankly, is understandable. The majority of these witnesses, however, gave credible and compelling testimony about their efforts to deal with mental illness and the defendants' system. The court accords that testimony significant weight in making its decision.

Mary previously lived in Massachusetts and had a high-level administrative job. *See* Pls.' Ex. 63. She went through a devastating divorce, lost her job, and lost her insurance. She was admitted to AMHI in 9/01 and twice since that date for extreme depression and post traumatic stress disorder. On 1/24/02, she was discharged from AMHI. At the time of discharge, she had a case manager in the hospital. The week she was discharged, she was transferred to an Intensive Case Management program. It was a very difficult and scary transition because she had a very good rapport with her case manager at AMHI. She asked to stay with her original case manager but was told that that was not an option and that she had to be in an Intensive Case Management program.

***52** She spent five weeks finding an apartment she could afford. At AMHI, she was in discharge transition in December, so she started right away looking for apartments, but she had to find an apartment she could afford. She lives in Gardiner because that is where she happened to find an apartment. She knew no one in Gardiner except her case manager. She has no family or friends in that area.

When she left the hospital, the BRAP (Bridging Rental Assistance Program) program paid her security deposit and two months' rent. She then received a letter informing her that she had to pay the security deposit back. She had no money. If she had been told about the repayment requirement, she would have tried to save the money. Mary stated that "it is one battle after another."

She received no help paying her rent. She submitted her name for approval for Section 8 housing, which would have saved her $300.00 a month. With $300.00 extra dollars, she would have been able to do more physical activity, because she could not afford exercise classes at the time of her testimony. Instead, she does yoga herself and enjoys that because it relaxes her and energizes her. She has been on the Section 8 housing list for ten or eleven months and has heard nothing.

Mary used the word "scary" throughout her testimony. She said it is scary to know that you have a mental illness and that you will have it for the rest of your life. She needed a psychiatrist but could not get one because she had no Medicaid or Medicare. She received an interim psychiatrist from the AMHI grounds. She also could not obtain a private psychologist or therapist because of the lack of Medicaid and Medicare.

She received too much in Social Security Disability benefits to qualify for Medicaid but she does not have enough money to pay for therapy after her living expenses. She is frustrated. She does all the phoning for appointments and her depression and PTSD are worse when she is stressed, which results in readmission to the hospital. She feels that therapy would help her with better and new coping skills so she would not being overwhelmed.

She had heard that the squeaky wheel gets the oil, so she began calling her ICM every day for two weeks, but, still, nothing happened. She stated that her case manager tries, but the system is not designed to give the case manager power and her case manager verified that fact.

She returned to AMHI in 6/02 and 8/02. She had no therapist during that period of time; she needed someone to talk to. In November, 2002, she was desperate again and did not want to go to AMHI. She bypassed the ICM and approached the CDC, who was in the same office as the ICM. She previously had not known she could speak directly to the CDCs. She did not want to alienate people because they are her helpers. She finally received a therapist and her therapy is coming along.

She has serious abuse issues, but there is no trauma help in the Augusta area. There is a class at night in Bath but she can not drive at night. She asked her ICM whether she could meet the woman who deals with trauma for the Department, presumably Ms. Jennings. Her caseworker and her caseworker's boss said that was not appropriate.

***53** At the time of her testimony, she had received Medicaid with a $3,000.00 spend down. In June, 2002, she was approved for counseling, but it did not begin until September, 2002. She has been approved through 4/24/03, assuming there is money, but there are no plans for after that date. It will take a minimum of six months simply for her to trust the counselor and she needs a several years of therapy. It makes no sense to her to get involved and then stop. She does not know if she even wants to bother with counseling, is discouraged, and does not want to have to continue to do all the leg work herself because she finds it very stressful. ¶¶ 66, 67, 70. She finally asked her case manager what the case manager's responsibilities to her were.

Her first admission to AMHI was because of an overdose. On the second admission, she felt like she was going to overdose again so she went to AMHI and asked for help. She has not used the crisis system because she does not trust that system. Her crisis plan now provides that she can call her case manager, she has a neighbor she can call

until 9:00 p.m., she can call her psychiatrist, she can call the police department twenty-four hours per day, and she can call another friend until 10:00 p.m.

Mary was complimentary about her stay at AMHI. The doctors, nurses, activity workers, social workers, and psychiatrists were helpful. She has not had a similar experience since her release. She stated that her case manager is a nice woman, but is not effective because the system gives her no power. She states that the system focuses on a certain group with an income of $400 or $500 a month. The people know what to do with that population, but anyone else is a big problem. She is often referred to as "the one who falls through the cracks."

She describes the system as "horrific." She believes she is higher functioning than some and does not need to be taught how to use a copy machine. But she needs groups and she needs physical activity and she wants a job. She is trying to maintain herself but there is no way to get services.

Mary said that she thought that she presented herself fairly well during her testimony but if we had seen her on a previous day, we would not have wanted her in the courtroom. She would like to work for the mental health system. She is aware of people's problems and perhaps she could make a difference.

The brother of the plaintiffs' twenty-second witness was a patient at AMHI beginning in 9/95. *See* Pls.' Ex. 64. The witness became his brother's guardian in 3/94 after his brother had a traumatic brain injury. The class member was bipolar previous to the injury and was involved in a head on collision when he was on his way to being admitted to AMHI.

Until 12/94, the class member was in Northport and then was in the VA hospital for five months. In 2/95, the witness applied to the Bayside Clinic in Portland for his brother. An application was pending for housing. In 6/95, the class member was accepted at a group home and began the Bayside program. From 2/95 to 6/95, he was at Togus.

***54** After the accident, he basically had to relearn motor skills. He has problems with short-term memory and still suffers from bi-polar but he can feed and take care of himself.

The witness hoped that Bayside would continue the physical therapy and occupational therapy because his brother needed more help. They also wanted behavioral counseling and hoped that part of the plan would include help to overcome the class member's behavioral problems.

There were incidents of aggressive behavior, after which the class member was admitted to JBI and to AMHI. Between his injury and the AMHI admission, he received mental health services only from Bayside and from the VA. The class member stayed for three months at Bayside but was discharged in 8/95 from his housing because of poor behavior. He could continue counseling at Bayside but he had no place to live. The witness lives in Belgrade and his brother, who previously lived in Winslow, had never before lived in Portland.

A discharge plan was developed at AMHI. A case manager referred the witness to Lakeview. The witness did not remember whether he was advised that his brother could live in a facility with fewer than eight people. The witness contacted Lakeview, and took his brother to visit one week later. In October, 1995, the class member moved to Lakeview, where he currently resides. Maine Medicaid paid for the admission to Lakeview.

The class member lived in the main house at Lakeview, which is the largest facility. In 1996, he moved twice to a group home, the Victorian home, once for two or three months and once for one and one-half years. He has returned to the main house.

In 1996, when his brother moved to the Victorian House, the Department stated that it would not pay for the class member's board. The witness wrote to Melody Peet and Kevin Concannon and met with Ms. Gianopoulos. The witness said that his brother was doing well and should remain at Lakeview. Lakeview tried unsuccessfully to find a place in Maine to replicate what his brother was receiving at Lakeview. Finally, Ms. Gianopoulos agreed to fund the class member's stay at Lakeview.

In 2/98, CDC Sue Whittington went to Lakeview with someone from Motivational Services regarding a potential move of the class member to Maine. The witness agreed that his brother could move as long as he received the services in Maine that he was receiving at Lakeview, which focus on behavioral intervention. The care his brother receives is primary. Nothing resulted from this meeting and his brother has remained at Lakeview.

The witness participates in the treatment decisions and authorizes them. His brother now has a full range of services at Lakeview, including physical rehabilitation, occupational therapy, and working in a workshop daily. The behavioral integration plan is working well. From 1996 to 1997, Lakeview worked with his brother and developed a strategy to meet his needs. He has had no psychiatric admissions since he's been living at Lakeview. During the eight years that his brother has been at Lakeview, the witness has received no contact from the Department regarding the Consent Decree.

***55** The witness has told the Department that his brother needs twenty-four hour per day care and needs a behavior

program that does not include drugging him into a coma and sending him to AMHI at the first difficulty. This witness's experience is that Lakeview is trained, dedicated, and knows what it is doing.

The witness would like his brother to live closer to home but Lakeview is only two hours away and the travel is not burdensome. The witness visits his brother three or four times a per year and brings him to Maine approximately six times per year. The witness knows that his brother is in a safe haven at Lakeview and that there is no similar program in Maine.

The plaintiffs' twenty-fourth witness is the mother of a class member. *See* Pls.' Ex. 65. The witness is employed at Spring Harbor as a psychiatric nurse.

The witness received extensive orientation and participates in discharge planning if a person is discharged during her shift. A form is used to ensure that the person understands medication and follow-up services. The witness has, on average, two discharges per week. The patients usually go home, to group homes, or to the homeless shelters. She was concerned about the number of people who were going to the homeless shelters and contacted Attorney Bailey.

The witness's son is 37. He has a fifteen-year history of dealing with the mental health system in Maine. He is profoundly deaf. He is fluent in sign language and lip reads quite well. He can use his voice, but his mother states that you have to know him to understand what he is saying.

In the summer, 2001, her son lived in an apartment in Portland. He was evicted from the apartment on 8/18/01 and stayed either with friends or at the Oxford Street Shelter. He can not stay with his mother. His diagnosis is schizophrenia and he has hallucinations and delusions. When he is sick, he wants to kill his mother; when he is well, they have a good relationship.

His social worker is Barry Martin, who is an employee of Deaf Services through Goodwill. They applied for a group home for this class member in 8/01. He was in the shelters and staying with friends. In September, 2001, he went to the emergency room at the Maine Medical Center and was discharged to Broadway Crossing. He was fragile and hallucinating. He stayed at Broadway Crossing from 9/1/01 through 10/5/01. During his stay there, he was admitted to Mercy Hospital for medical reasons and returned to Broadway.

He then was sent to the YMCA. His mother thought that that placement would be short-term because he had applied for the group home. She was very concerned for his safety because he was placed on the fifth floor of the YMCA and he would not know if there was a fire. The YMCA does not have a TTY system. He was very stressed living there; deteriorated, and was voluntarily admitted to the psychiatric ward at Maine Medical Center for a week. He was discharged and was quite upset because he had to go back to the YMCA. He stayed at the YMCA until he was admitted to Spring Harbor. He remained on the waiting list for the Forest Avenue home. He was at Spring Harbor for one week and was discharged back to the YMCA. He remained at the YMCA until mid-March.

***56** The witness was concerned because every time her son is sick, his personality is eroded and he never quite returns to his previous level. He has a degree in graphic arts but, at the time of her testimony, he could not even hold a part-time job.

On the December 1, 2001, she called the CDC office. She told Ms. Tagney that her son would be readmitted to the hospital if his accommodations did not change. On 12/19, he went to the Maine Medical Center emergency room. He was at Spring Harbor from 12/20/01 through 1/16/02; he was delusional and threatened to kill her.

At a meeting at P-6 at Maine Medical Center, the housing people said they would have taken her son but he did not have a discharge plan and a discharge plan from a transitional home is needed when a person is admitted to the transitional home. The social worker, Barry Martin, was surprised to hear about that requirement because no one had told him that a discharge plan was needed.

The witness noted that she is a psychiatric nurse and yet she was having difficulties navigating the system. After reading a Casco Bay Weekly article, she called Peter O'Donnell and had a meeting with him on 2/12/02 to discuss her concerns about the lack of community support and her son's residing at the YMCA. Her son had been on a waiting list since August, 2001. At the end of February, they met at Deaf Services at Goodwill with Mary Tagney, Barry Martin, and people from Deaf Services. Claire Harrison discussed this client with Goodwill and asked that Goodwill stay involved in the case. The witness's son was admitted to the Forest Avenue residence during the third week of March., 2002. From August '01 through March of '02, while waiting for appropriate housing, this class member had four hospitalizations and a stay at Broadway Care.

Plaintiffs' twenty-fifth witness has a disease she referred to as RSD. *See* Pls.' Ex. 66. She's been in a wheelchair since 3/1/02. Prior to that time, she was able to walk and worked full-time. She is 31 years old. She was last admitted to AMHI in 1993 for approximately one month. She was not taking medicine for mental health issues at the time of her testimony.

She has an ISP and a case worker, Kelly Carbone, from

Support and Recovery Services (SRS) in Portland. This witness's goal is to address her emotional needs and to find a therapist. She has had a therapist off and on but stopped seeing the latest one in March because the office was not accessible physically. The witness told her case worker immediately when the therapy ended and told her that she needed another therapist because she found the therapy helpful. The witness went through the phone book but could not find another female therapist with an accessible office. Ms. Carbone was also unsuccessful in finding a therapist. As of the time of her testimony, Ms. Carbone had found a therapist who was taking new patients but the witness had not yet met the therapist.

Her most recent ISP, dated 12/02, provides that she will attend groups regarding her disease, RSD. That was not her goal at the time of her testimony although that was a goal until March, 2002. She stopped going to the group because she was too sick. Even though her last day at work was 3/1/02, her plan dated 3/28/02 indicates that her work helps her.

***57** The witness was asked whether she got along with Ms. Carbone. After a long pause, the witness responded that she gets along with Ms. Carbone and likes her as a person. The case worker helps on the little things. The witness stated that Ms. Carbone "does not have the resources." Ms. Carbone is not helpful on important things or during a crisis. For example, when she was in crisis, she talked to Ms. Carbone but the outcome was to schedule an appointment for the next week. The case worker's supervisor interceded and the witness went to the crisis stabilization unit (CSU). There was no discussion or offer of in-home supports.

This witness has not received any other mental health services. During past crises, she has used crisis support but found it very frustrating because there are usually no openings, especially in Portland. Her last hospitalization was a year before her testimony. They looked at Broadway Crossing at that time, but there were no beds and the facility was not accessible. Her last crisis was in 7/02. She was having a hard time dealing with being in a wheelchair. She met with Ms. Carbone and told her she was in crisis at that time. They called Ingraham but Broadway Crossing was full.

The witness finally went to the CSU in Saco, run by CSI. The next morning, the staff told the witness that she did not belong at the CSU because they could not deal with her disabilities. The witness asked the staff, "where do I belong"? They told her to go to a hospital but she did not feel that she needed to be hospitalized. The CSU had a ramp to get to the door but very narrow doorways with no room for her hands to work the wheelchair. The beds were too high and she could not use the shower or toilet in the bathroom, which resulted in some accidents. She also could not get into the kitchen.

Mary Anne Mills, the nurse supervisor at CSI on the crisis unit, testified that this witness did not fall at the CSU. That testimony is contradicted by the records of the witness's stay at the CSU. *See* Defs.' Ex. 140. The notes of 7/12/02 at 7:30 a.m. provide that the client "was falling in between her chair and the toilet." The notes of 7/13/02 at 1:55 p.m. provide that the witness "transferred from we to toilet with great difficulty, mostly as a consequence of fixture configuration." The notes of 7/13/02, 11:00 p.m. make clear that the staff is not allowed to help this patient with bathing. Ms. Mills was also unfamiliar with regulations for accessibility.

This class member stated that it is hard enough to deal with depression and that she was really hurt when the staff told her that she did not belong at the CSU. The issues that brought her to the CSU were not addressed. The focus was instead on the inability to deal with her. Her mother was dying, she was not able to work, she was in a wheelchair, and she had no therapist: "everything was just kind of stuck."

She has had prior suicide attempts and during this crisis in 7/02, she was trying to do the right thing. She felt worse when she left the CSU than when she arrived. When a woman on the staff named Enid Gorman went through the discharge procedure, she asked the class member what had been accomplished while she was at the CSU; the class member replied, "absolutely nothing." *See* Defs.' Ex. 140 (7/13/02, noon). She returned home and told the CSU that she "would get through it" because the staff was concerned about her emotional state. The staff had made it clear that the witness was not welcome there. Enid Gorman recommended that the witness call the DRC.

***58** This class member wanted to leave the facility earlier but could not leave because transportation was unavailable. If her CSW had been called after discharge, the notes would have reflected that call. There was no documentation that her CSW was called.

Since 7/02, this class member has had other crises. She talks to Ms. Carbone, whom the witness can call Monday through Friday from nine to five. This class member can go to the hospital or she can call Ingraham, but she finds that unpleasant. She said that Ingraham overreacts when the staff sees her history of suicide attempts and the staff sends the police to her house. As a result, she has not called Ingraham for a long time and has told her case worker that Ingraham is not an option. Usually, this class member just needs someone to talk to.

She has also gone to the emergency room in crisis. She sat in the room for a long time and saw the social worker or the doctor for a very short period of time. Hospitalization was recommended because of her history. She has been hospitalized three times during the last few years.

She has a crisis plan but she did not sign it. She saw the plan for the first time the week before her testimony. In March, June, and September, 2002, no crisis plan was attached to her ISP. *See* Pls.' Ex. 97. The plan does not discuss going to the hospital or to Ingraham. The plan is "more for them than me," according to this class member. She needs a crisis plan to work for her because she does not know where to turn. She will not call Ingraham because the police are called. She stated that "makes me feel like a criminal. I am not a criminal. I am trying to do the right thing by talking to people."

Joseph Cyr was an involuntary patient at AMHI in 1990s for a few weeks. He was not told about any services on discharge. ¶ 53. He was put on heavy medication and had no CSW and no psychiatrist. After discharge, he found his own psychiatrist.

He received cards in the mail from the Department. Each time he received a card, he called the number listed. He hoped he would get services because the card said he was a class member. At first, the telephone line was always busy. Eventually, he made contact and was told that someone would visit in his home but that visit never took place. Finally, he obtained an appointment and a person went to his house sometime between 1995 and 1998. The person showed Mr. Cyr the list of services and asked about his income. Because Mr. Cyr owned a 1965 trailer, which needed repairs, he was told that he would not be eligible for any housing or any services.

Mr. Cyr never responded to the cards after that visit until 9/02. He figured what he had been told him was a fact. He next was told he could have a CSW if he had Medicaid, which he obtained in 5/02. He met with the CSW to develop a plan for services. The CSW helped him obtain food stamps and they discussed recreational services and social clubs, although Mr. Cyr is afraid to go to the clubs. He finds the services, including a therapist and a psychiatrist, helpful. He needed these services prior to 2002, twelve years after his discharge from AMHI.

***59** Stephen Wilson was admitted to AMHI two or three times in the mid-1980s and the early 1990s. He has received services from Tri-County in Lewiston, Bridgton, and Portland on and off since 1982. His last services were in early 2001 at the Bridgton Tri-County. He discussed various goals and objectives with his CSW, including health care. *See* Pls.' Ex. 69. They discussed his teeth but his CSW did not think he was entitled to services. His sister finally got him an appointment at a dental clinic. An x-ray was taken but that was all that the clinic could do for four or fives months. He ultimately pulled his teeth out himself because they were so loose he was not able to eat.

He has experience as a dairy farmer, in the military, at the post office, in the health care field, in construction, and real estate. As of 7/00, he was unemployed. The ISP vocational goal did not resolve his employment problems because they had nothing to offer him. He had had responsible jobs. He obtained an entry-level minimum wage job at The Big Apple but he spent $40 or $50 a week just to drive to his job. Everything was left on his shoulders. No one encouraged him. Some things he can do but some things he can not do. He remained unemployed at the time of his testimony. *See* Pls.' Ex. 69.

The services Mr. Wilson asked for were not available or did not meet his needs. He disagreed that he was unsure what he wanted. *See* Pls.' Ex. 70. He was sure what he wanted but nothing was available. He received letters from the Department but he received no response when he called the number. His CSW eventually left Tri-County to work with children.

Mr. Wilson stated that even though the trial was getting him agitated, he would not call Tri-County because it would take six months before anything would be done. If he has a crisis, he will go to the emergency room.

Richard Cromett was admitted to AMHI in 1988 and diagnosed with schizophrenia. He goes to Mid-Maine Mental Health Center every three months where, he stated, they try to keep him calm with medication so he will have no bad thoughts. He obtained an appointment on an emergency basis at the AMHI dental clinic but there was a waiting list for non-emergency matters. The clinic people said "don't call us, we'll call you." Mr. Cromett received no call for three years. Two weeks before his testimony, he called and got an appointment.

Mr. Cromett told Bruce Samuels that he wanted to finish getting his teeth fixed before he started another goal. Bruce Samuels told him to do it now because Mr. Samuels thought they are going to get rid of the class members because the Department has filled all of their needs. Mr. Samuels called Mr. Cromett once to ask how he was doing.

Mr. Cromett member does not know what a CSW is but assumed that it was someone to guide you in what you want to do in life. A few months before his testimony, he discussed this with Bruce Samuels. He has never had a CSW but he would like one. ¶ 53.

***60** Linda Deblasi was admitted to AMHI during the summer of 1990. She has had sixteen hospitalizations since at Spring Harbor. She just was released from Spring Harbor on 2/7/03, the day of her testimony.

Previously, she lived in Portland but she was evicted; she was off her medicine because someone stole it. The police took her to the Maine Medical Center emergency room. She was taken to Spring Harbor and blue-papered. She

was court-ordered to stay five business days but her stay was extended to seven. After her discharge, it was decided that she would go to the Oxford Street Shelter, although she did not want to go there. She put all of her things in a storage bin and she got "most" of them back. She has been at the Oxford Shelter a couple of times. Her case manager also arranged for Ms. Deblasi to go to the Women's Crisis Center but it took one month to get into that shelter.

She next lived at The Bridge beginning in July or August, 2002. Since 10/02, she had lived in South Portland. The apartment she currently has is not subsidized. She was on the waiting list for Section 8 housing and had been since October, 2002. She was accepted for BRAP but her apartment was too expensive. At the time of her testimony, the total rent for her apartment was $741.00; she paid $374.50, which included all expenses, because she had a roommate. Her case worker Joan appealed the BRAP denial, but she had not heard about any decision.

She was at Spring Harbor four times during the summer, 2002 and was blue-papered each time. She called Ingraham and the worker took her to Maine Medical Center and then to Spring Harbor. Ingraham took her dog and the dog was adopted from the animal shelter. She was discharged to the Oxford Street Shelter during several admissions at Spring Harbor. She dislikes the Oxford Street Shelter because the people there have poor hygiene and it is impossible to sleep because there are too many people and only mats, not beds, are available.

When she is in crisis, Ms. Deblasi calls Ms. Leaman, who does the assessment and takes Ms. Deblasi to Ingraham or to Maine Medical Center. Ms. Deblasi prefers Spring Harbor or Broadway Crossing, although sometimes she cannot get into Broadway Crossing because of capacity. Ms. Leaman talks to Maine Medical Center to ensure Ms. Deblasi's choices are known.

She got along well with her case worker, who worked with Catholic Charities, and saw her weekly. A second case manager had been assigned Ms. Deblasi, who was assigned two case managers because of her higher needs. Because she was part of the ACT Team, she could have a nurse; she and her case worker were working on getting a nurse. She had in-home supports on Sunday. The staff took her out into the community and made sure she was not isolated.

Cynthia Dow had been admitted to AMHI on two occasions, July, 1997, and October or November, 2001. At the time of her testimony, she received community mental health services. She had a CSW from Catholic Charities and she was involved in an independent living program through Motivational Services. She received DBT counseling at Kennebec Valley Mental Health Center and had an ISP.

***61** She previously lived with her husband in South China. She went to Acadia for a month on an involuntary basis and then transferred involuntarily to AMHI directly from Acadia by ambulance.

She had treatment team meetings at AMHI and she had a social worker. Her discharge plan began at the end of October or beginning of November, 2001. She was told that she could not go home and that she had to go to an apartment. She did not participate in the decisions; they were made by doctors and her husband.

She wanted to be out of AMHI by Thanksgiving because she was feeling pressured by her family. The psychiatrist at AMHI told her she could leave AMHI when she found an apartment. That process took three and one-half weeks. She wanted to use the social worker's free phone to call potential apartments but she finally called from AMHI and paid for the calls herself.

She found an apartment in Waterville for $450.00 per month; her friends took her to see the apartment. Because she was discharged from the hospital and was not allowed to go home, she was considered homeless. She paid the entire amount of rent herself for six months. After six months, she could have received BRAP money but her landlord refused to sign the necessary paperwork, even though her social worker had known where she was going to live. She left that apartment because in order to receive BRAP money, she had to have been in the hospital during the previous six months. That time was expiring, she knew it could not be extended, and she needed an apartment where the landlord would sign the necessary papers.

Although her CSW from Catholic Charities knew about this situation, Ms. Dow made all of the necessary phone calls. This CSW was assigned to Ms. Dow before she was admitted to AMHI but did not come to any treatment team meetings and did not help her get BRAP money. After the problem with her landlord, she moved to Augusta and then moved again.

She was taking DBT counseling, which teaches emotional regulation, stress tolerance, interpersonal effectiveness, and the ability to stay focused. She stopped this counseling because she was taking classes at UMA and became overwhelmed. She enrolled in the classes through the vocational rehabilitation people. When a dispute arose about whether the Department or vocational rehabilitation would pay for her classes, she advocated for herself to the University and received scholarships.

She advocates for herself and has for three or four years but she can not always do that because it is very stressful. For example, it was very stressful to be at AMHI and it was only because of her persistence that she was

discharged by her goal of Thanksgiving. She was angry with the people who were supposed to help her but did not. She thinks about the people who can not advocate for themselves. She feels frustrated and anxious but determined.

Gayle Huntress is the mother of a class member who has grand mal seizures, epilepsy, and a heart problem. In 1991, this class member went into cardiac arrest and a coma and sustained a traumatic brain injury. Her IQ is now 52 and she has developed secondary psychosis. She has a twelve-year-old child, who lives with her and her mother. Ms. Huntress's daughter was at AMHI from July through October, 1992. Upon release, she lived with her mother and she lived at Lakeview for six years. This class member was one of the patients discussed by Ms. Diamond.

***62** Lakeview is one hour and fifteen minutes from Ms. Huntress's home. She visited her daughter one time per week with her grandson, who was approximately five when his mother went to Lakeview. Ms. Huntress brought her daughter home to Maine for short visits and they talked on the phone.

Ms. Huntress participated in the discharge plan at Lakeview, which took one year to complete. They had a difficult time finding an agency to help. They requested a CSW from CSI. Ron Paquette stated he did not think that this class member belonged in the community and he was not willing to assign a CSW for her. He said that her status was too complicated, although he had not met her. This class member has lived with her mother since January 30, 2002.

In 2/02, Ms. Huntress met with Linda Santeramo from the Department and Cheria Clough, who was a CSW at CSI. Nancy Diamond at Lakeview and Ms. Huntress had comprised a lengthy list of needs for her daughter in order for her to be able to live successfully in the community. Her daughter was already in Ms. Huntress's home at that time of the meeting. They reviewed the list to determine how these needs could be met. Included were safety in the home, respite beds if there was a crisis, medical needs, transportation, and recreational therapy. Ms. Huntress believed from discussions with Ms. Santeramo that the needs could be met.

As of the date of her testimony, there was no respite bed for her daughter, which Ms. Huntress considers the utmost, paramount need. Ms. Huntress does not know what she would do if her daughter goes into crisis. She does not want her to return to AMHI, which Ms. Huntress termed "the worst case scenario." There is no crisis plan and the facilities will not accept people with complications. On the advice of the CSW, Ms. Huntress had called crisis intervention. Her daughter was examined and evaluated but because no bed was available, her daughter was taken to AMHI.

On rebuttal, Ms. Santeramo testified that a crisis plan for this class member had "just recently" come to her office. On cross examination, "just recently" was defined as 2/10/03, four days after Ms. Huntress's testimony. The ISP review process for a crisis plan was not done correctly for this class member.

This class member has had crises in the past; her mother keeps her at home during those crises. Ms. Huntress calls Maine Medical Center and speaks to Dr. Joshua Cole on P-6. If there is no bed available, her daughter has no option except AMHI. Ms. Huntress was told that respite care is not available because Medicaid does not pay for it and the care has to be paid for by Consent Decree money. If there is no crisis plan and no money for respite, Ms. Huntress fears that her daughter will clearly not be able to live in the community.

Ms. Santeramo also suggested that a return to Lakeview is an option if this class member's condition deteriorates. The issue, as far as Ms. Santeramo is concerned, is back in the CSW's hands. Ms. Huntress loves her daughter and wants her to live at home because she deserves to live in her home with her son as long as she can. Ms. Huntress recognizes that that may not be forever.

***63** The plaintiffs' thirty-second witness's most recent release from AMHI was a week before his testimony in February, 2003. He was blue-papered because he had been very depressed. His diagnosis was obsessive compulsive disorder, anxiety disorder, eating disorder, and major depression. In 10/00, he was a victim of road rage and sustained a head injury.

He stated that the system has failed him in every direction he has turned and he has given up. He sits at home because he is unable to go anywhere. He has a car but it is broken. He cooks but he has problems remembering things and he has had several fires.

He was previously at AMHI during January, 2001. He was blue-papered to BMHI and transferred to AMHI. He has also been a patient at Seton, St. Mary's, JBI, Maine Medical Center P-6, and Maine General. He has been voluntarily and involuntarily admitted. He has lived in the Gardiner area most of his life. He would prefer to have his hospitalizations in the Augusta/Gardiner area because his family is there and his dog is there.

During his last stay at AMHI, he believed he was treated very poorly. He was medically sick and was taken to an appointment with a medical doctor. He returned with an order that provided that a medical doctor should be called if he had certain symptoms. He told the nurse that he had severe pain and showed her the instructions but his request to see a doctor was refused. The nurse told him

that they do not go to the emergency rooms and AMHI had only one medical doctor on weekends.

His last CSW was Vicky Tourtelotte in 1998. Ms. Tourtelotte stated that she did not have a good working relationship with this client. She received approval from the CDC to close his case. She did not recall if she requested that another CSW be assigned. She did not discuss with him having another worker. She did not send a notice of the proposed termination of services to him. Although she knew that persons with traumatic brain injury had memory issues, fluctuating moods, and problems with anger, those issues were not discussed with him regarding termination of services.

This witness has not had a CSW since Ms. Tourtelotte. He would like to have another CSW who would help him succeed. He does not want another CSW who simply makes excuses about why appointments are canceled. He needs help getting a security deposit, going to school, and fixing his vehicle.

He received a Notice to Quit, which provided that he had to leave his apartment by 12/20/02. He called the Region II Consent Decree office when he received the notice. The Region II people said no funds were available. He has called about a security deposit from wrap-around funds but was told no funds were available every time he called. He has also asked the City of Gardiner to help with the security deposit but the City does not pay security deposits. He called the Maine Human Rights Commission, the DRC, and everywhere else about a security deposit. He did not know how he would move and he had no place to go.

***64** According to Ms. Kluzak, this class member is welcome to apply for BRAP funds. His previous funds were terminated in 1999 for non-payment of rent. *See* Pls.' Ex. 91. The witness had told the housing people that his rent money was stolen. At the time, they knew that he needed or was getting a representative payee and Ms. Kluzak agreed that one could assume he was having difficulty managing his finances and paying rent. In spite of these issues, no communication other than a 7/7/99 letter about stolen rent money was sent to this class member's ICM before termination of BRAP funds. The termination notice was not sent to the ICM. Ms. Kluzak agreed that no outreach was done for this witness after the funds were terminated.

The termination notice sent to this witness did not notify him that he could file a grievance or make a different arrangement regarding rent. *See* Pls.' Ex. 91. At some point, the form was changed to inform clients what can be done if a balance of rent is owed.

This class member wants to be as independent as he can, but he has very limited income and transportation problems. He receives SSI; his mother manages his money for him. In January, 2003, he called the vocational rehab office and spoke to Peter, who said the waiting period was six months. Two days ago, he called the ICM program, a number he stated from memory, 287-9170, and was told no funding was available. He was also told that if he wanted a case manager, there was a waiting period and that they would get back to him. Therapy has helped him in the past and he would like to have it again but the problem is transportation. He was receiving no treatment at the time of his testimony.

Juanita Bradstreet's last hospitalization at AMHI was in 1988 or 1989. She had also been admitted to St. Mary's for ten or more admissions during the past fifteen years. She had also been admitted to JBI and to a hospital in Brunswick. *See* Pls.' Ex. 2.

In 1/02, she received services from Tri-County Mental Health, including a case manager, a psychiatrist, and group counseling. From 8/8/00 until 5/02, she waited to start DBT therapy. She never dissolved her goal for this therapy and never lost interest in having the training. At the time of her testimony, she enjoyed the therapy and said that it helps her tremendously with coping skills. She is now in college and is receiving DBT therapy. The therapy was unavailable to her until May, 2002. ¶ 63.

Ms. Bradstreet has been hospitalized for many attempted suicides and for depression. Most of these hospitalizations were voluntary, although a few were involuntary. At the time of these admissions, St. Mary's did not take blue-papers so she was admitted at JBI or AMHI.

On occasion, she would voluntarily go to a psychiatric hospital, although she stated that this really was not voluntary. In the emergency room, the crisis worker for Tri-County told her that if she did not go voluntarily, she would be blue-papered. She signed the voluntary papers because she was scared and because on an involuntary admission, she stayed in the hospital longer and found it was harder to get released.

***65** The plaintiffs' twentieth witness was admitted to AMHI in the summer, 1994. *See* Pls.' Ex. 61. He had been admitted to fifteen or sixteen psychiatric hospitals since that time. He was diagnosed with bi-polar and post traumatic stress disorder. At the time of his testimony, he was taking 2400 mg of lithium to control his bi-polar disorder. In the past, he medicated himself with alcohol. When he becomes depressed, he either becomes suicidal or homicidal.

He spent five years at the Maine State Prison for an aggravated assault conviction. He received no case management during that period. Just prior to his release, Mr. Gardiner from SRS spoke to him for about fifteen minutes. He was released from prison in 7/00. He walked

out of the prison with $50.00. He had no appointments, no clothes, and no place to live. He was homeless.

Commissioner Duby agreed that there is a problem regarding transitioning from the jail to the community. This issue was raised two years previously with the Court Master and as a result, "initiatives" began.

His family helped this class member and eventually, he was able to ask for help. He asked for some money to get clothes and household items; the request was denied because he wanted more than $500.00. He appealed to the Department and in 12/00, he received a $1500.00 grant from wrap-around funds. On cross-examination, he was interrogated about small amounts of money he may have received and whether he has repaid these amounts. He was repaying some of the wrap-around funds currently at the rate of $25.00 a month. He had informed the Department that he will pay all of the money when he receives VA benefits. He had not asked for the money for luxuries but for things like security deposits and a winter coat so he could go to the doctor.

He received services from the Department through SRS. For the past sixteen months, his CSW had been David Hodgkins. This class member believed that Mr. Hodgkins sincerely attempts to help him in the community, but Mr. Hodgkins's caseload is too high. Mr. Hodgkins takes the witness to the food bank, to medical appointments, and to appointments with Dr. Dingley. The medical and psychiatric appointments have to be rescheduled often because Mr. Hodgkins is too busy.

This class member received in-home support services from Ingraham for approximately one year. *See* Pls.' Ex. 62, p. 2/8. The services were terminated within 90 days of 3/11/02 due to "changes in policy." *See, e.g.,* Jt. Ex. 29; Pls.' Ex. 32. He has not had any in-home supports since that time.

He received a letter from Ingraham regarding the termination because of Medicaid regulations. *See* Pls.' Ex. 60. Ms. Foerster told him that Medicaid placed a one-year limit on in-home supports and his supports were terminated because they would not be paid for. When this witness told her that he was a class member and asked whether he could appeal, she told him there was no recourse. In spite of the projected termination, he had no discussions with Mr. Hodgkins about revising his ISP from 3/11/02 through 5/14/02. The in-home supports helped this witness interact with people, which he does not do well. He described it as a "work in progress" until it ended.

***66** He received medicine and interim services from Dr. Dingley, a psychiatrist who is an employee of the Department. *See* Pls.' Ex. 62, p. 1/8. This was not a permanent arrangement, although he received these services at the time of his testimony.

For one year, he had been requesting individual counseling. Mr. Hodgkins has tried to facilitate the counseling but stated that he has "no clue" when he will find a counselor.

This witness stated that he is a pretty good advocate for himself but finds it unbelievable to try to accomplish anything in the system. Even though he has insurance and even though he is a class member, he finds the system like walking through a mine field. He was asked by defendants' counsel whether he was working toward recovery and he replied, "very desperately."

Lauri Donoghue testified about her sister, a 45-year-old class member. *See* Pls.' Ex. 59. Ms. Donoghue has always had close contact with her sister, except from 6/97 through 1/99 when Ms. Donoghue lived in Pennsylvania. Since September, 2000, she had been her sister's power of attorney and had been able to make medical decisions.

Ms. Donoghue's sister was first admitted to AMHI in 1985 and had four or five subsequent admissions to AMHI, Spring Harbor, Seton, and to facilities in Massachusetts. In the latter part of 2000 through 2001, Ms. Donoghue visited with her sister every few days and sometimes daily. Because her sister has resided in Lakeview since spring, 2002, Ms. Donoghue now visits her sister once a month, although she tries to visit more than that. Lakeview is a two and one-half hour drive from Ms. Donoghue's home.

Prior to residing in Lakeview, her sister received community services through the ACT Team at Tri-County. When Ms. Donoghue returned to Maine, she found her sister living in what Ms. Donoghue described as squalor and filth on Lisbon Street in Lewiston. Her sister was being exploited and abused and was in a constant state of drunkenness. There was no food in her house and there were always people in her house, including criminals. Ms. Donoghue stated that her sister looked like she was 100 years old and looked like she was falling apart.

The DHS is this class member's guardian. Ms. Donoghue was involved in the guardianship proceedings, applied to be the guardian, and became temporary guardian on 2/18/01. She wanted to be her sister's guardian but she was convinced by the guardian ad litem that the DHS had better resources than she and that the Department and the DHS would work together to give her sister help. The permanent guardianship was awarded to the DHS. The guardianship did not revoke the power of attorney, which Ms. Donoghue continued to hold. In response to the defendants' question about whether Ms. Donoghue had any training in brain injuries, she noted that she had taken a twelve-week course in brain disorders to understand

better one of her sister's diseases.

Ms. Donoghue was able to get her sister admitted to the detox unit at St. Mary's. She then went from St. Mary's to Spring Harbor and then to Hearthside in Sidney, which is a dual-diagnosis house for alcohol and mental illness. Tri-County convinced Ms. Donoghue that Hearthside was the appropriate place for her sister. She resided there for a few months. Ms. Donoghue discussed with the guardian taking care of her sister's needs, which included a need for glasses and a broken foot. Ms. Donoghue was eventually told by a worker at Hearthside that her sister was too sick to be at Hearthside. They talked about putting dignity back in her life. Ms. Donoghue signed the necessary papers and authorized the move from Hearthside to Lakeview. The move occurred within a few days. No one has ever told Ms. Donoghue that her sister has the right to live in a facility with fewer than eight beds, including when her sister was residing at Hearthside and Lakeview.

***67** Ms. Donoghue visits Lakeview when she does not have to work and when she can afford money for gas. She was invited to one treatment team meeting, which she attended. She was "put in her place" at that meeting and was not invited again until January.

Louis Laplante, the case manager for Lakeview, said that Ms. Donoghue's power of attorney was in question. The DHS wanted to take the power of attorney because the DHS stated that the fact that the DHS was the guardian and Ms. Donoghue was the power of attorney was very confusing to providers and that her sister cannot have two people making decisions. At the time of her testimony, Ms. Donoghue had been served with papers regarding this issue but there had been no hearing.

Ms. Donoghue was concerned about her sister because her needs, including dental problems and her foot, had not been addressed. As of 1/16/03, there was no plan in place to deal with her sister's foot problem, which had been a problem since before she resided at Hearthside. Since 1999, Ms. Donoghue had been requesting dental help for her sister. She had an appointment a few weeks prior to Ms. Donoghue's testimony. The dental work could not be attempted because her sister was too ill for the work planned and had to take antibiotics because her mouth has become so infected. Ms. Donoghue was not allowed to be part of the planning process. When Ms. Donoghue advised that her sister's clotting problem was going to affect the ability to pull teeth, she was reminded that she was not the guardian.

In 1999, Ms. Donoghue began requesting battered women classes for her sister. Ms. Donoghue mentioned this request to everyone she had contact with, including Shirley Davis at the DHS. As of 1/16/03, nothing had been done with regard to this issue.

Her sister received eye glasses seven or eight months after the initial request. Her sister has sight problems and wears glasses at all times.

As noted, her sister also has a clotting factor problem. When Ms. Donoghue raised this issue, the people at Lakeview seemed surprised. Ms. Donoghue is concerned about how Lakeview would respond to an emergency if the staff did not know about this problem. She had previously told the DHS about the clotting problem.

Ms. Donoghue believed that her sister can not handle what was expected of her in the house she resides in at Lakeview. For example, she was supposed to cook for the house residents on occasion and she was too tired and too sick. Further, there was only one other woman in the house. This upset her sister because she had been raped and sodomized frequently. She was also the only woman in a van full of men when they travelled to AA meetings.

Her sister is unable live on her own and needs an assisted living situation with personal care. There was no plan for how long Ms. Donoghue's sister will remain at Lakeview and the DHS had not said how long she will remain there. Ms. Donoghue had asked that her sister return to Maine although Ms. Donoghue believed that the address has never been as important as obtaining the appropriate treatment for her sister. According to Ms. Donoghue, her sister is a Maine citizen, her family is here, and she should have care here.

***68** As of 1/16/03, when Ms. Donoghue was last at Lakeview, there was no plan to provide the same services in Maine as are provided at Lakeview. Ms. Donoghue had spoken to people at the DHS and the Department. Sheila Hall from the Department had no plan for her sister. Sheila Hall said they will "play it by ear" and will "look around." Sheila Hall said that when Lakeview says that her sister is ready to leave, that is when Ms. Hall will worry about it.

Ms. Donoghue has applied to be her sister's guardian. After all of this history, Ms. Donoghue stated that "she needs me to be her guardian."

Kimberly Walker has worked at Tri-County in the Oxford Hills unit for nine years. She has been a CSW since 6/96. She was the case manager for the plaintiffs' twenty-third witness, who testified about problems with the workers from Richardson Hollow, the former provider of his in-home supports, which had terminated. The workers did not keep scheduled appointments and did little for this class member when they did arrive.

Nothing was done about the in-home supports problem. Ms. Walker explained that the "empowerment model" is used in dealing with clients. Tri-County supports the

empowerment model and she had learned it through experience. This model gives the client decision-making authority on all matters. Work is "client driven" and the CSW and client work on only what he wants to work on. Although this class member stated to her that he was not happy with some of the workers, he did not want to do anything about the issue. The problem with the in-home supports was, therefore, not listed in the ISP as a barrier because "this is [his] plan." If he doesn't discuss a problem, it is not included in the plan.

A goal was dissolved regarding socialization and peers for this class member. Upon review, she said she probably should have designated the goal "achieved" and written a new goal. His current ISP had no socialization/peer goal. He continued to be lonely and isolated but they had not addressed those issues currently. As of 9/12/02, he wanted to work on life stresses and depression and anxiety and he wanted access to therapists. The target date for these goals is 9/12/03. Although she has offered him a therapist, she did not suggest anyone to him and did not offer a personal opinion.

D. AMHI Hospital Treatment and Discharge Plan

Superintendent Kavanaugh testified that there are processes in place to sustain improvement with regard to involvement of community support workers, including orientation, training of staff, and discharge planning. She wanted to involve CSWs in a variety of ways and to document that involvement. She stated that AMHI expected that the CSWs would be physically present at team activities but because they are a scarce resource, they were not always at the table. In fact, according to the Superintendent, CSWs were probably present half of the time; the chart reviews show that a 50% attendance rate is accurate. *See* Pls.' Ex. 5. AMHI needed consider teleconferencing and other ways to involve the CSWs as opposed to their being physically present. Although Superintendent Kavanaugh maintained that there are other ways that the CSWs were involved, that involvement is not reflected in the patients' charts.

***69** Superintendent Kavanaugh agreed that the chart reviews show that putting a copy of the ISP in the chart was an area that AMHI needed to work on to improve. As of 1/25/02, she testified that this was an area they felt they were doing a good job at but we could do better. In 9/01, a copy of the ISP was in only 25% of the charts. *See* Pls.' Ex. 5.

As a member of Administrative Executive Committee (AEC) as of 1/25/02, Superintendent Kavanaugh knew that there were some areas in which AMHI could do better. The chart reviews certainly support that testimony. She was unable to comment, indicator by indicator. She agreed that patients' receipt of the RRMHS was not a subjective requirement. That was identified as an issue, although she could not recall when. It was referred out.

Superintendent Kavanaugh agreed that the requirements of paragraph 80 are important to good treatment and discharge planning in order to ensure continuity of care. When asked when AMHI first began collecting data regarding timeliness of referrals pursuant to paragraph 80, she replied that somebody else could answer that question better than she. When asked whether she knew whether AMHI tracked all referrals of patients' requests for a CSW, she stated that Dr. Wisch could answer the question better than she. She admitted that there was a problem in documenting involvement of CSWs at the treatment team meetings before 1/25/02.

Superintendent Kavanaugh would not admit that placing the ISP in the chart was a problem during the last year. She said it was something that they worked to improve and that they tried to do better. She was not aware if this had been a problem for a particular patient and she was not aware this was something AMHI was not doing. *See* Pls.' Ex. 5; ¶ 75. She did not know what was being done to get ISPs in the file.

With regard to getting medical records for patients who were admitted, she testified that AMHI tracks when the records are requested but she was not aware of any tickler system to determine whether the records had been received. She was not aware of any tracking either for ISPs or medical records. Superintendent Kavanaugh agreed that assessing patients' psycho-social needs was an area to improve. *See* Pls.' Ex. 4. As was her wont, she declined to say this was a problem but was, instead, "an opportunity to improve." She stated that the statistics, which included 54%, 58%, 50%, and 45% compliance rates for assessing psycho-social needs for October, 2001 through January, 2002, met her definition of substantial compliance but it is an area that needs continued improvement. *See* Pls.' Ex. 20. Such figures do not meet any definition of substantial compliance. She stated that this data came to the attention of the AEC and that was why a contract social worker was hired. The contract social worker was hired in 2001, however, and the data were from April, 2002. Again, she stated that someone else might be better able to answer these questions.

***70** She agreed that the data regarding informed consent for patients was a trend or concern. *See* Pls.' Ex. 4. She believed that this issue had been raised with the AEC but did not remember when. Although she testified that AMHI would have asked the Director of Medical Records and the Director of Nursing to look at the data, she did not specifically recall doing that and the clinical pertinence review report provides that no charts were referred to the committee. *See* Pls.' Ex. 4.

There is a mistake on the clinical pertinence review report

in the determination of the percentage of initial treatment plans being done with 72 hours. *See* Pls.' Ex. 4; ¶ 76. The chart states this was done 90% of the time; the figure should be 60% of the time (18/30). She did not know of any process to catch such errors. Accordingly, the percentages before filing for substantial compliance for this category were approximately 60% or 65%. When asked if this was a problem, she had no answer other than to suggest that she would look at all the months to see whether it was a problem.

She sees the concurrent chart review reports on the AEC. She was unable to testify regarding any trends of concern. She agreed that a review of an open chart was important to the patient because the chart was open and changes could be made while the patient was still admitted.

Ms. Whitzell noted that patient at AMHI is expected to receive the patient information booklet on admission by the MHW. *See* Defs.' Ex. 18. The patient is also expected to receive the RRMHS on admission. *See* Jt. Ex. 8. Although these documents are expected to be given to the patient and their receipt documented on a form, Ms. Whitzell learned in August, 2002 that it had not always been documented that the patient got a copy of the RRMHS. She asked the staff to check and make sure that the patients received the RRMHS and documentation was made.

Ms. Whittington discussed the requirement that AMHI use the ISPs in treatment plans. Some CSWs attend treatment team meetings; some attend by phone or fax materials for the meeting. *See* Defs.' Ex. 6. As discussed, the evidence makes clear that CSWs' attendance at these meetings is sporadic. The CSWs are also expected to be part of the discharge planning process. If the consumer begins the ISP process in the hospital, the CSW has an opportunity to establish a relationship with the client.

For training, the CSWs are expected to interact with AMHI staff. The CSWs receive protocols from AMHI and training on bridging the gap between the hospital and the community. That training is offered to all hospital social workers, AMHI social workers on staff, AEC, and community providers.

The training manual provides that forensic patients who have been found not criminally responsible (NCR) and are expected to remain at AMHI for an extended period of time do not need immediate referral for a CSW. Unlike the previous manual, in the revised 10/02 manual, social workers will refer within 90 days NCR forensic patients if they will be allowed to spend time in the community. *Compare* Defs.' Ex. 51, p. 42 *with* Jt. Ex. 23, p. 38. She did not know when this change occurred.

***71** Long-term civil patients require an ISP within 30 days. Ms. Whittington does not attend the AMHI treatment planning meetings. The AMHI social workers are responsible to track the involvement of CSWs with AMHI patients. Ms. Whittington believed that the utilization review (UR) nurse reviews CSW involvement in EI beds. She did not know who reviewed non-EI beds. If she sees a long hospital stay without an ISP, she discusses a need to have an ISP. That information is not, however, on the ISP form and is not collected by the CDCs.

Dr. Nelson also testified about paragraphs 76-80.

E. Community Hospital Treatment and Discharge Plans

Ms. Smyrski previously supervised UR nurses; that supervision ended in 2000. There was no evidence about the training the UR nurses received from 2000 through 1/25/02. When that issue was raised by plaintiffs' counsel, she then stated that there had been no changes by the Department regarding the roles of the UR nurses' review of inpatients commitments since 2000. No basis for that conclusion was offered and that conclusion is not accepted.

Ms. Smyrski testified about the Department's "expectations" for the UR nurses. In 1997, the Department hired three UR nurses, supervised by the regional medical directors, to monitor hospitals' adherence to the RRMHS and the Consent Decree requirements. The Department expects that any hospital with an agreement with the Department will be reviewed by the UR nurse. The Department expects hospitals to notify the UR nurse regarding admissions. The expectation for the UR nurse is to visit the hospitals in their area on, at a minimum, a weekly basis. The expectation is that within five days of hospitalization, an initial review by the UR nurse will take place and the UR nurse will determine that the client was notified of his rights, was committed by the proper procedure, whether the client is a class member, whether the CSW was notified and involved in treatment, whether the ISP is incorporated in the treatment plan, whether active treatment is occurring, what the treatment modalities are, and whether there is a need to be referred to a special consultant. *See* Jt. Ex. 11(b). The UR nurses are expected to follow a patient to make sure that if a client requires inpatient care, the client is receiving appropriately active treatment. *See* Jt. Ex. 11(c). This review becomes part of the patient's chart and is put into the database. The UR nurse is also expected to ensure compliance with paragraph 83.

The checklist does not include the basic Rights of Recipients. Although Ms. Smyrski tried to suggest that the "notification of rights" section on the checklist included the basic rights, there is a separate section in the Rights of Recipients for notification of rights. *Compare*

Defs.' Ex. 11(a) *with* Jt. Ex. 8, pp. 9 & 11. She then stated that notification versus compliance with rights is not different. She then finally agreed that there is no specific section on the checklist for the basic rights. She agreed that there is nothing on the checklist regarding the least restrictive appropriate setting. *See* Jt. Ex. 8, p. 10.

***72** When she was asked whether there was anything on the checklist to verify compliance with the grievance procedure, she replied that the form was not meant to be all inclusive and that the hospital is responsible for these procedures. There are no other forms used by the UR nurse. *See* Jt. Ex. 8, p. 14. There is nothing on the checklist that refers to the right to be free from abuse, exploitation, or neglect or rights regarding personal property. *See* Jt. Ex. 8, p. 38(f) & (h). There is nothing on the checklist that refers to the additional section titled "Basic Rights." *See* Jt. Ex. 8, p. 58. She stated that that did not mean they are not reviewing other things. She was asked whether the checklist contemplates verification of all of the seclusion and restraint requirements. *See* Jt. Ex. 8, pp. 63, 67. She said that the "documentation standards met" would require the nurse to follow the path in the documents. Ms. Smyrski based this conclusion on conversations with UR nurses.

Ms. Smyrski does no review to determine whether a person was admitted to the hospital closest to home. She was unaware whether there was any discussion on admission about whether the patient could have gone to a facility closer to home. Apparently, this is another "expectation" because a requirement of compliance with the Consent Decree is part of the contracts. *See* Defs.' Ex. 49, Rider E, pp. 2-3; *See also* Defs.' Ex. 64 (Community Hospital Acute Psychiatric Inpatient Services).

The UR nurse also is expected to accompany the DHS surveyors on at least one day during the DHS licensing procedure for hospitals the Department contracts with. The UR nurse is expected to advise the DHS surveyor regarding Rights of Recipients. *See* Jt. Ex. 11(a). This checklist is used only for hospitals with psychiatric units because the Department does not attend licensing visits at assisted living centers. A copy of this checklist is sent to the DHS licensing team and the UR nurse keeps a copy; the information is not put in the database. A random chart review is expected to be done and the UR nurse has instructions about how to proceed if she finds deficiencies. The UR nurse is expected to report to the hospital's CEO and the hospital manager. The expectation is that the hospital will submit a corrective plan to the DHS. The UR nurse is expected to report her concerns to the clinical team and to the unit for which she is doing the review. She can report to the regional Medical Director if the concerns are very serious.

Copies of the UR plan were sent to all the regional offices. Ms. Smyrski was not sure whether this UR plan was attached to quarterly reports. She said there was no need to attach the UR plan to the 5/02 report although she agreed that the plan shows how the Department expects to comply paragraph 83.

For purposes of paragraph 83, "class members whose admissions are funded by the Department" is interpreted by the Department to mean admissions funded by the Department's contracts, which cover individuals with MaineCare or who are indigent.

***73** The defendants are unable to show that they can identify and meet needs of the class members. That failure affects this section specifically, as well as other areas of the Consent Decree. *See, e .g.,* ¶ 279.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 49-50, 52-53, 55-58, 61-70, 73-83 of the Consent Decree.

VII. COMMUNITY RESOURCES, SERVICES AND PROGRAMS: Paragraphs 84-111

The focus of paragraphs 85-87, 93-96, 97-98, 101-102, 103-104, 107-108 is on ISP-identified needs. As discussed, the CMA permits tracking of data but assessment of whether the class members' needs are identified and met is lacking.

A. Hospitalization

The following community psychiatric hospitals take involuntary admissions: Southern Maine Medical Center (three beds), Mid-Coast (two beds); Saint Mary's (nine beds, including three for elderly psychiatric patients); Maine General (four beds); Spring Harbor (average thirteen to sixteen beds). In the early 1990s, the Department had a contract with Aroostook Medical Center but that contract is no longer in place. Aroostook Medical Center continues to accept involuntary patients but does not require funding. The Department does not have a contract with Acadia but it accepts involuntary patients. Hospitals funded by contract include PenBay, Maine General, St. Mary's, Mid-Coast, and, in the past, Southern Maine Medical Center. Other community hospitals with inpatient units are funded by insurance, self-pay, Medicare, and Medicaid. Ms. Smyrski stated that there is an "expectation" that voluntary admissions meet legal criteria and the appropriate level of care must be given.

She negotiated contracts for involuntary care until 1998. Changes in the contract language since that time include language about transfers to AMHI. *See* Defs.' Ex. 49.

The training the Department provides to hospitals

includes the Bridging the Gap program in Region I, Consent Decree requirements, and training for professionals regarding the grievance process. Ms. Smyrski was unaware whether Region III received Bridging the Gap training. The CDCs told her that the training occurs in Regions I and II; the training has been funded in all regions.

The Department's contract with the Southern Maine Medical Center is not current, although she stated that the hospital continues to receive funding as needed for indigent patients involuntarily admitted. The hospital is now a nondesignated hospital for the purposes of the statute. According to Ms. Smyrski, the hospital continues to operate as if a contract were signed. Spring Harbor is also a non-designated hospital. When asked by plaintiffs' counsel what would happen if a grievance were filed by a patient at Southern Maine Medical Center and the Commissioner were asked to decide the grievance, she testified that "I can not speak for the Commissioner ." The evidence shows what the Commissioner would do. *See* Pls.' Exs. 2 & 3.

***74** Although Ms. Smyrski testified that these hospitals still are required to comply with the law with regard to commitment, she agreed that all hospitals have to comply with the law with regard to commitment. With regard to designated hospitals, the Department has two beds at Mid-Coast, nine at St. Mary's, four at Maine General, and three at PenBay. Although she testified on direct examination that the Department now has 42 beds, she agreed on cross-examination that in 1996 the goal was 36 beds and the Department now has eighteen designated beds. *See* Jt. Ex. 1, p. 53.

A patient potentially is in a different status in a designated hospital versus a non-designated hospital. Ms. Smyrski agreed that in a non-designated facility, a patient who filed a grievance receives a hearing but cannot appeal to court. During training, the grievance process is described for agencies funded by the Department. If an individual is in an agency funded by the Department through contract, there are clear provisions for the grievance process. If the Department does not have a contract with the agency, Ms. Smyrski stated that it was beyond their legal purview to make demands with regard to, for example, a voluntary patient in a non-designated hospital. If an involuntary patient changes to voluntary, however, the patient is not considered non-designated status because the status on admission is determinative. If a patient enters a hospital voluntarily and changes to involuntary status, he is eligible for the grievance process as long as the hospital is funded by the Department. If there is private insurance, Ms. Smyrski stated, "who are we to impose?" If class members who have Medicare and can pay the extra 20% are involuntarily admitted to hospitals with which the Department has a contract, they are not beneficiaries of the contract. If the patients are self-pay, the Department is not involved.

Ms. Smyrski's testimony, including her expectations for hospitals and her expectations for the UR nurse, discussed in section VI, does not show compliance with these paragraphs.

B. Housing

Commissioner Duby agreed that the class members' housing needs have not been met 100% as of 1/25/02. She would have had to refer documents to determine the percentage of the needs that had been met. At the time of her testimony, the Department had developed a strategic plan regarding homelessness and was "just about" to launch a specific action plan. It has done the strategizing and will now begin the work.

Commissioner Duby agreed that significant part of the homeless population is chronically mentally ill and that the level of utilization of homeless shelters of Maine is now very high. That testimony is confirmed by Robert Rockett, an outreach counselor for the Oxford Street Shelter in Portland, which houses single adults or married adults with no dependents. The shelter does not operate under a contract with the Department; the City of Portland operates this shelter. He has worked at the shelter for four and one-half years and has been a Licensed Clinical Social Worker since 8/98. His duties include outreach to unsheltered and sheltered individuals at Oxford.

***75** The shelter is currently operating at maximum capacity. The shelter has an overflow plan, which involves the YMCA and the Salvation Army, for times when the shelter is full. The people the shelter serves have more needs than those who were served in the past. There is a core group of people with mental health issues who stay at the shelter on a nearly permanent basis. They have higher needs and are more resistent to accepting services on a voluntary basis. The group that lives at the shelter permanently has doubled in Mr. Rockett's four and one-half years of experience. During winter, there is usually a drop in the rate of people using the shelter. During the winter of 2001-2002, there was no significant drop.

He has contact with class members on a daily basis. He has observed that when class members arrive at the shelter, the ICMs give high, first priority to the class members. The first question asked is, "are you a class member?" and if so, that class member takes priority over others in need of service. The witness has had class members tell him that they are class members as if to say, "you better watch out." Although Mr. Rockett stated that everyone is important and everyone receives the services he needs, there is no sense of immediacy if the person is a non-class member.

He refers class members to case management and they receive services immediately. More often than not, they already have a case manager and are in touch with the system. With non-class members, the standard procedure is followed. Non-class members need Medicaid, have to have been hospitalized more than one time, and must have an Axis I diagnosis. If they have all those requirements in place, Mr. Rockett usually can find someone to work on outreach with them. Obtaining permanent, long-term case referrals takes longer.

The people who go to the shelter are referred from the jail, the police departments, and from "every direction imaginable." They come also from Spring Harbor, from P-6 at Maine Medical Center, and from caseworkers in Regions I and II.

On a weekly basis, people arrive at the shelter directly from the hospitals. Caseworkers call from the hospitals and before Mr. Rockett can get back to the caseworker, the person has arrived at the shelter. People discharged indirectly from AMHI to the shelter. These people are not directly transported from AMHI to the shelter because that is not part of their discharge plan. Because they do not have other alternatives, however, they end up at the shelter.

He interacts with the crisis system. It is difficult to get a worker to come to the shelter. The client really has to be in crisis; otherwise, the worker tells the shelter to send the person over to the worker. If the client is not saying that he will kill himself and naming the method to do that or that he will kill someone else and naming the method to do that, the client will not get blue-papered. Even if the person is blue-papered, the person is released quickly. During the week before Mr. Rockett's testimony, a person was blue-papered from the shelter and was back at the shelter in a few days. That scenario occurs weekly. Voluntary hospital admissions are rare and those patients are released even more quickly than the involuntary patients.

***76** Crisis stabilization beds are not often available to the people Mr. Rockett works with. He tries to access the beds but he has not been successful because there are insufficient numbers of beds. There is a waiting list of up to a year to get into long-term residential supported living, regardless of class member status.

Tobin Gardiner, who testified under subpoena from the plaintiffs, has been the intake coordinator at SRS at Catholic Charities of Maine for ten months. He has a B.A. in psychology and has been a Licensed Social Worker since approximately 1987, when the licensing first began. He coordinates all paperwork to determine whether someone is eligible for services. He maintains the case management/CSW waiting lists.

In order to obtain a CSW, the patient or someone from the hospitals call him. If the person meets the requirements and has MaineCare, the person is placed on a waiting list. Ten months ago when he began this job, the wait list for case managers included 130 to 150 people. All had a hospitalization and a major mental illness diagnosis. They were on a waiting list because they wanted services and the services could not be given to them because there is an insufficient number of CSWs. The waiting period was from six to nine months to a year if the person had Medicaid. The wait period was well over one year if the person had no Medicaid.

This process has since changed and a person must have Medicaid to be placed on the waiting list. If a person is hospitalized, has a major mental illness, and has no Medicaid, the person is not placed on the waiting list. Class members, however, are scheduled right in. Thirty or forty people have been removed from the waiting list because they do not have Medicaid; their removal has nothing to do with their diagnosis. They are informed that they don't have Medicaid so they are off the list. There is no follow up to determine what happens to the people who are removed from the list and he has not been asked to follow up on those people.

Before his current job and until 1/02, he was a housing coordinator for the same agency for more than ten years. He helped people find housing and the subsidies to pay for it. He is familiar with all of the services available from housing authorities, BRAP, and the Shelter Plus Care (SPC) program. The clients of his agency have past psychiatric hospital stays and an Axis I diagnosis. Thirty to fifty people per month went to SRS looking for housing in Cumberland County, where it is very difficult to find housing. In Portland, there is a 2% or 3% vacancy rate; people who have little money and also have poor references and tenancy histories are often shut out. The average length of time required to locate housing can be from three days to one month, depending on references and funds. The housing shortage results in people staying in the shelters longer.

Since April, 2001, Martha Kluzak has been the Region II housing coordinator. She has a B.A. in psychology. Previously, she worked with Motivational Services, which has a contract with the Department. She also worked for the Elm Street Group Home, which is a Housing and Urban Development facility.

***77** She coordinates BRAP, SPC, tries to help resolve housing needs, writes grants to develop housing, and assists tenants in obtaining resources. She becomes aware of housing needs directly from class members or their guardians or from ICMs and CSWs. She talks to regional providers to learn about housing needs and she assumes they get their information from consumers. In spite of that

testimony, she stated that she did not know whether providers maintained waiting lists for housing.

She has had conversations with class members regarding whether they want to reside in a smaller facility. Two individuals said that did not want to leave Elm Street. It was their home and they wanted to live there the rest of their lives in spite of seeing others leave.

Since 1998, she has chaired the Region II Homeless Group, which assists homeless people obtaining housing. Her job includes informing the local groups about resources and how to access them. Since 2001, they have sent outreach workers to shelters. The Continuum of Care is homeless funding, including housing, food, transportation, etc. She is involved in housing.

BRAP is a state-funded program which provides housing assistance to class members and individuals with severe mental illness. This program bridges the gap from during the period when a person applies for Section 8 housing and finally gets that housing. There is no waiting list for BRAP.

This program has been in effect since 1994. Since that time, 3000 people have enrolled; one-third have been class members. The program provides security deposits and on-going rental assistance for two years. If the person is not in Section 8 housing by the end of the two-year period, the assistance can continue. This is completely statefunded and is the budget for the current year was $1,100,000.00. She reviews the funds monthly to see if funding is at appropriate levels and given to eligible people. During the last biennium, either all or nearly all of the funds were used.

The BRAP funds are administered by Motivational Services except for waivers, which are done by the housing directors and coordinators. She meets weekly with the ICMs and Motivational Services. If a person applies for those funds but has no ICM, the application is reviewed by people who have no relationship with the person. These applications are reviewed weekly and the decision is communicated to the applicant. The tenant has to find an apartment. If the tenant has an apartment, the assistance starts immediately. A release is used to give confidential information to this group to determine eligibility. *See* Defs.' Ex. 51, p. 4/6, § 3.

Class members are automatically eligible for BRAP assistance and are prioritized over everyone. They have to ensure that they are eligible for Section 8 housing, which requires income from SSI, SSD, or general assistance. Class members do not have to meet priority standards.

At the time of her testimony, funding was not an issue; the program was open. The wait list for housing in Augusta and Waterville was 30 months. If there is a simultaneously filing for Section 8 housing and BRAP, a waiver of the 24-month duration requirement is needed. She has not denied waivers to class members; she has denied waivers to non-class members.

***78** The BRAP manual is used by housing directors and housing coordinators in each region. Ten local administrative agencies administer BRAP and SPC and use this manual. It was revised 10/02. It has been continuously revised for the past two years. *See* Defs.' Ex. 51.

SPC is a federal subsidy to homeless people with disabilities. Those people pay 30% of their monthly income for housing and SPC pays the remainder up to the fair market rent value. This is intended to be permanent housing but the people are encouraged to apply for Section 8 housing as a safety net. The Department is the grantee of funds and the funds are administered through the local agencies. An array of housing options is available: group homes, residential facilities, apartments, and home ownership program. Individuals can choose the type of housing they want provided it meets housing standards and falls within 110% of the fair market rent value. SPC does not maintain a wait list because this program is specifically for homeless people with disabilities. All slots were full at the time of her testimony. Class members are not automatically eligible because SPC is a federal program. Both BRAP and SPC are tenant-based subsidies, which follow the tenant. PATH is a funding source of $300,000.00 administered by nine agencies. With regard to BRAP, SPC, and PATH, her office is expected to conduct on-site evaluations to ensure eligibility and that legal requirements are being met.

She administers the housing discretionary money, $25,000.00, for Region II. All of this money was used in the previous year. This money is used for security deposits, a new well, a new toilet, and similar needs. The money is administered like wrap-around funds and is discretionary money. She instructs CSWs and case managers to publicize these available funds but she does not notify class members that the money is available. There are no policies governing the administration of this money. Although she has never denied a request from Region II, there is no policy regarding notice or appeal if the request is denied.

Wrap-around funding is not administered by her but she tells people it is available. These funds also can be used for security deposits, damages, reasonable accommodation requests, mortgage arrearages, and similar requests. This is a last resort funding, which available to any mental health consumer. The Maine State Housing Authority, Coastal Enterprises, and the home owner assistance programs are available for home ownership.

She co-authored a housing resource manual in 2001. The first printing was in 7/02 and the second printing was in 9/02. *See* Defs.' Ex. 50. Consumers have this manual but the principal audience is CSW's and case managers. Previously, they used the "purple book" and pamphlets regarding BRAP and SPC.

A 30-day notice is given for termination of a housing subsidy. She was not familiar with the provisions of paragraph 69 of the Consent Decree. She then testified that termination of housing is not covered by paragraph 69 of the Consent Decree because that paragraph deals with services and services are separate and distinct from housing. No basis was offered for this conclusion.

***79** With regard to Sewall Street and a program in Waterville, Motivational Services leases the premises from the landlord and Motivational Services then leases to the client. Within the three months prior to her testimony, Ms. Kluzak learned that the residential agreement provided, inappropriately, that the tenant had to leave the apartment if services were terminated. *See* Pls.' Ex. 43. She discussed removing this language with the executive director of Motivational Services. She had not checked lease and rental agreements for the Elm Street Facility, although she had checked others. She requires separate service and housing agreements only if the facility is subsidized by BRAP, SPC, or Section 8 because those are the programs she is involved in.

Within the year before her testimony, she was invited by Ms. Smyrski through Bruce Samuels to pass out surveys to individuals residing at the Elm Street Group Home as on 1/25/02 regarding their right to live in a smaller facility of fewer than 8 beds. *See* Pls.' Ex. 40A; 41 (individual refused to sign); ¶ 96. She did not develop the form but received copies from the CDC Office. *See* Pls.' Ex. 40A.

Initially, she did not recall any dates for this survey. She finally recalled that her practice would have been to send the survey out sometime around September or October, 2002. She had never done anything previously as housing coordinator to monitor informed consent of people living in facilities with more than eight beds. She sent these forms because she was asked to do so by the CDC office.

The limitation on homes which exceed an eight-person capacity was modified by the court with regard to Mount St. Joseph's in Waterville. ¶ 96. There were no other waivers.

Sheldon Wheeler has been the Department's Statewide Housing Coordinator since March, 2000. He previously worked in New York as Deputy Housing Director for a large community based organization and in Vermont for a for-profit housing agency.

He helps provide access for agencies to housing capital for renovation and for new construction for housing for consumers. This includes the Federal Home Loan Bank of Boston, section 42 federal tax credits, Maine State Housing Authority, Community Development Financial Institutions, funded by the U.S. Treasury, and the 1994 and fall, 2001 bonds passed by the people of Maine. Continuum of Care is an example of funding source. HUD funds the Continuum of Care. There are three in Maine: Bangor, Portland, and statewide.

He job involves assisting agencies to access money and leverage money from other resources and educating the Public Housing Authorities (PHAs) regarding the resources available. The participants include individual agencies or institutions which address homelessness. His job also involves assisting people obtain below market loans or zero percent interest loans to create housing units.

The housing coordinator's discretionary fund totals $125,000.00. Mr. Wheeler did not know how that figure was determined. There is no analysis of whether the funds are adequate or how they are used. They have "templates." His office has no guidelines for the administration of discretionary funds in the regional offices.

***80** The Department has received SPC funding since 1994. In 2001, the Department received $600,000.00 and in 2002, more than $1,000,000.00. There are federal guidelines in place for PATH and SPC, the federally funded programs. There are templates regarding guidelines and these are reviewed by the state auditor.

The Department recently received more than $1,000,000.00 from a five-year grant for SPC. They have to apply for the grants annually. He has administered SPC funds of more than $10,000,000.00 since March, 2000.

The Maine State Housing Authority administers bonds. The 1994 bond helped generate 200 units. The Department, in discussions with the Legislature, Maine State Housing Authority, and federal authorities, provided ground work for the fall, 2001 bond issue of $12,000,000.00; $2,750,000.00 was for mentally ill consumers. In his experience, it takes two years to develop a bond issue and six months to build. Its very difficult to predict when this bond money will be fully expended.

The Maine State Housing Authority is working on a request for proposals for utilization of these funds as follows: $750,000.00 will be used for Continuum of Care, $1,000,000.00 for chronically homeless with mental illness, defined as homeless for thirty days within a twelve-month period and those days can be non-consecutive, and $1,000,000.00 for housing. The

Department is involved in the RFP, which will go to the providers in the community, hopefully within two months of the date of his testimony. The providers are encouraged to leverage funds.

A unit is an apartment or a bed in a group home. One unit equals at least one individual. Defendants' exhibit 111 shows the housing units developed statewide. *See* Defs.' Ex. 111. These numbers include supported living services beds, but he did not recall those figures.

The Shalom House cumulative report shows the number of vouchers issued for BRAP. *See* Defs.' Ex. 112. These figures have been part of the Department's compliance reporting since 7/01. There is a slow but steady increase in the use of BRAP funds.

The Department does not keep track of any requests for BRAP that were denied or the reasons for the denials. He is aware of individuals who refused to apply for Section 8 housing and were refused BRAP funds. Those individuals were not class members. He is aware of a Section 8 guideline for vouchers and certification that provides that someone pay more than 50% of his income for rent. They have discussed an appropriate level of BRAP subsidy but if the income level required is reduced, the number of participants in BRAP would be reduced.

He agreed that rents have increased throughout Maine during the last two years and that there is an increased burden on mental health consumers because of the increase in rent. BRAP funding can be used for rent up to 110% of the fair market rent value. The fair market rent value is a figure that the federal government uses; the last increase in the figure was in 10/02. He tries to have a data source to show HUD what the fair market rent value actually is for areas of Maine. He was unable to describe the variance because he said there are multiple markets throughout Maine and he did not have the data. He said that in certain neighborhoods, for example Portland, the fair market rent values are 50% of the actual rent figures.

***81** A waiver is needed to go beyond 110% of the fair market rental value. The Department keeps track only of the number BRAP waiver requests that are granted; the number of denials and the reasons for the denials are not tracked. He was not aware of any waiver request denied to a class member; he was aware of waiver requests denied to non-class members. If a person falls outside of the priorities and is not a class member, only occasionally would that person get BRAP funds through a waiver. The BRAP manual has a guideline for waivers. The most common waiver is the twenty-four-month waiver to extend BRAP funding. There are 380 BRAP vouchers in use today; approximately 30% are used by class members.

Some PHAs have stopped taking applications for Section 8 housing. This has occurred in Biddeford and Sanford but not Portland. There was recently a 30% cut in administered funds pursuant to federal legislation. As a result, the Department did a budget projection over two years in August, 2002 and determined that it would go over its budget in the next biennium. A budget request to address that situation has been made for the deficit amount. If the funding is not granted, the Department will have to implement priorities. Previously, the Department was able to fund any individual who was eligible. A mental health consumer who pays more than 51% of his income for rent but does not meet the priorities would not be eligible. Rent burden is not considered as an eligibility requirement for BRAP.

The Home Owner Assistance Venture Program has no funding currently but the structure is kept in place. The home ownership program involves state funds. He does not know the number of class members who used these funds. The Department does not keep track of the numbers. There is no plan to refund this program.

Mr. Wheeler has been assigned to a group that includes DHS, the Department, DOC, and others to increase resources to homeless people with mental illness. There is legislation in Maine providing for an interagency task force on the homeless and housing opportunities. A "template" was created for interagency collaboration. A strategic plan to end homelessness has been prepared in Maine, which he believes was attached to the compliance report. He expects a report and an action plan to be developed within six months of the date of his testimony. The Department's housing coordinator is required to develop a plan to address homelessness.

The 10/01 task force report concluded that the homelessness in Maine is on the rise. When asked whether the number of people using shelter beds is at an historic high, he replied that he did not have specific data. Maine's percentage of homeless people with mental illness exceeds the national average. Twenty percent of people in shelters nationwide have mental illness; he did not know the figure for Maine. He said the Department has had several meetings and arranged for resources to be available to the community. This apparently occurred after 1/25/02.

***82** Mr. Wheeler prepares the initial drafts of the housing part of the compliance reports. Plaintiffs' counsel read to Mr. Wheeler the following sentence that appeared in several compliance reports: "No individual will be hospitalized for a lack of housing and hospitalization is for medical necessity only." Mr. Wheeler did not know where that language came from and he did not recall preparing it. He does not read the compliance reports before they are submitted and he does not read the housing portion of the reports. The housing office does not track whether people were hospitalized because a lack of housing. He does not track the impact of the length of a

hospital stay with regard to available housing and he does not track the impact of the length of a stay at AMHI with regard to available housing. Although Mr. Wheeler states that he reads the Court Master's reports, particularly with regard to housing, he did not recall the 06/01 needs of class members not in service report in the 12/01 Court Master report. *See* Pls.' Ex. 67.

There have been revisions to performance indicators in contracts with agencies providing housing. Effective 7/1/02, revisions were made clarifying and distinguishing the responsibilities. They made clear that SPC and PATH involved federal funds and BRAP involved state funds.

In August or September, 2002, the Department developed a survey tool regarding housing but had not distributed the survey at the time of his testimony. The survey was developed to ensure that services were useful and to determine how to improve services. Mr. Wheeler admitted that, prior to September, 2002, the Department did not have adequate information to make such a determination. In November, 2002, it was decided to delay distribution of the survey because Dr. Yoe believed that consumers were inundated with surveys. The survey will be implemented before 6/03.

During the fall, 2001, Ms. Smyrski looked at all of the paragraphs of the Consent Decree with regard to the issue of substantial compliance and at paragraph 96 in particular. She and others requested input from staff, including the regional housing directors. They discussed the typical process to refer an individual and admit an individual to a residential program. The action they took was the result of information they received.

She testified about her understanding of the practices regarding paragraph 96. She understood that it was a common practice for a dialogue to occur about where a person wanted to live and the number of beds in the facility but that there is no policy or clear procedure to document that that dialogue occurred. Ms. Smyrski was not offered as an expert and there was no showing that she had personal knowledge about this issue. Her understanding that this was just another documentation problem is not accepted.

As of 1/25/02, there were twenty-four individuals residing in facilities with more than eight beds. By September or October, 2002, three residents had moved out. Although Ms. Smyrski testified that in August or September, 2002, she developed a form to document as of 1/25/02 that the residential providers were discussing with the customers their right to live in a facility with fewer than eight beds pursuant to paragraph 96, the form does not accomplish that purpose. The form states only that "I have been notified of my right to live in a residential facility of less than eight (8) beds." *See* Defs.' Ex. 53. The forms are dated September or October, 2002. She notified the CDC office and the regional office housing director to speak to each of these twenty-four class members to assure that the dialogue occurred regarding their rights to live in smaller facilities if they wished. This procedure does not establish that as of 1/25/02, these individuals had been told about their right to live in a facility with fewer than eight beds.

***83** This form was developed before her deposition but after the plaintiffs' interrogatories were sent to the defendants. She stated that the interrogatories raised the issue to a higher level. She agreed that she developed the form for the purposes of this trial.

There is no written policy regarding discussion with clients of the right to live in facilities with fewer than eight beds but it is, once again, a "clear expectation." This is not a contract requirement and the Department has no clear monitoring process in place for the requirements of paragraph 96.

Ms. Smyrski did not know if other class members lived in facilities with more than eight people. Gray Manor, for example, is a facility for more than eight people. She did not know whether any class members lived there. She only focused her inquiry on class members who lived in programs that the Department funds or develops. She did not check any addresses to see where the class members live. She did not ask the CDCs to get that information from the CMA. Nothing was done after the forms were circulated to determine who lives in facilities with more than eight individuals and to determine whether they wanted to be there. In fact, a person moved into a facility with more than eight beds since the form was developed. She did not check to see if the person was a class member. She did not know whether the person had been given the form. It is an assumption that this discussion has occurred as part of the administrative process.

The testimony of the class members and relatives, Ms. Diamond, Ms. McFarland, the ICMs, Ms. Gianopoulos, and the testimony about the SLSs, as well as the above testimony show that the defendants are not in compliance with the housing paragraphs. *See also* Pls.' Ex. 67, pp. 3-7. Of particular concern is the defendants' failure to comply with paragraph 94; nineteen AMHI patients could have been discharged if available housing had been available. *See* Defs.' Ex. 31A. The defendants inability even to comply with a requirement to inform a person of the right to live in a home with fewer than eight people, and their unsuccessful efforts to obtain retroactive consent, are inexcusable.

C. Residential Support Services

Claire Harrison is the Mental Health Team Leader for the Department's Region I office. She has a Masters in social work with a clinical concentration. She is a licensed

clinical social worker.

She worked at Shalom House from 1977 through 1994. She also worked at CSI as a housing coordinator and director of services and at Community Counseling Center as housing coordinator, director of housing and support services and acting mental health team leader.

She works on contracts with agencies funded by the Department for adult mental health services. She supervises the CDCs and a representative of the Office of Consumer Affairs. She attends mental health team meetings at central office and works on special projects with central office. She is currently part of a statewide committee on co-occurring disorders, integrating substance abuse and mental health disorders. She serves on the statewide supported living services committee. She is on the QI Committee for the regional office.

***84** The Department has contracts with providers for supported living. Three levels of services are provided: residential treatment, residential support services, and supported housing. She described generally her view of how these are expected to operate.

Residential treatment within a congregate living situation is the most intense service. These services are assigned to beds. There are approximately fifty beds in Region I at eight facilities. These services are for individuals who have long-term, more intense needs and who have had a number of hospitalizations or very lengthy hospitalizations. They also have special needs, such as co-occurring physical illness. All beds are staffed twenty-four hours per day, seven days per week. The staff-to-client ratio is higher in these facilities and the staff receives more specific training. For some programs, an RFP is issued and the agencies determine the services they will deliver. Sometimes the Department works to develop a specific service. People reside in these facilities permanently.

A person must be MaineCare eligible to be admitted to a residential treatment facility. There are fifty beds and approximately thirty to thirty-five class members reside in these facilities. If an increase in services is needed and the person wants to use an agency other than the private non-medical institution (PNMI)-sponsored agency, that is possible. Eight facilities have operated under PNMI since it was developed.

Eighty people receive community residential services in twelve or fourteen facilities. Approximately one-half are class members. The population served varies. Some agencies own or lease the building, but the landlord is the mental health agency.

The Department contracts for community residential services and facilities in York and Cumberland Counties. *See, e.g.,* Defs.' Ex. 134. A staff member is present at these facilities twenty-four hours per day, seven days per week. Some residents participate in day programs, some in volunteer work, and some go to social clubs. Each has his own room and the facilities have a community living room, dining room, and shared bathrooms. The residents have weekly meetings to decide how they will share meal preparation and have household chores. This is permanent housing. Community support services can be provided by agencies other than the agency that owns the building.

Shalom House provides independent apartments in York and Cumberland Counties. There are eight units with a community room. Two units are shared and six are singles. The staff is not always on-site, but staff is always present overnight. This is intended to be permanent, long-term housing.

In-home support services are included under community residential services and are contracts. They are not included under the residential treatment section for funding. According to Ms. Harrison, in-home support means going to a person's residence based on need. She never sought guidance from the Court Master on this issue.

***85** There are some transitional community residential programs. The average stay is twelve weeks. These programs are designed for people who need support because they have just left a hospital, they are homeless, or they are looking for an apartment. The Bridge was specifically constructed for this purpose. Transitional homes include The Bridge, for homeless people with mental health issues; Randall Place, for people with mental health and substance abuse issues; Maine Stay, for homeless people with substance abuse or mental illness or both, which has no class members; and Shalom House, for people with mental health issues. If a resident needs long-term or permanent assistance, the person can work with a team from the community to apply for other programs.

The length of stay is to be determined through the team-based ISP planning policies. *See* Jt. Ex. 30. For the facilities listed above, however, the length of stay is predetermined.

There are eighty-five beds for supported housing services in Region I. The population is served in a group living situation or an apartment with some services. Staff is not always at these facilities. The residents may receive community support services or out-patient services. Some meals are provided but this is not a structured or programmed facility. For example, Brannigan House has ten residents in two-bedroom, shared units and studio or one-bedroom units with a community space. The staff is present during certain times of the day. Some people receive more services and some, less. A mixture of clients

uses these facilities.

Some community residential facilities are time-limited. If a person recovers but does not want to lose his residence, the person is required to leave if this is a transitional bed. For residential treatment or community residential facilities, the home and the services are linked together; when a person no longer needs the services, he must leave the facility. The Department has explored ways to let individuals convert to another funding mechanism so they do not have to leave if the level of services required changes. There was no method to convert at the time of her testimony.

Ms. Harrison works with agencies to match an individual with the appropriate facility. Referrals come from the Department and from AMHI or people apply. The contracts for residential treatment facilities have to be approved by the Department. With regard to the other facilities, the contract specifies the type of facility and the agency screens clients with its own screening tools.

The Department's efforts to monitor these facilities to ensure that people receive services include agencies' reports of outcome measures and the residential weekly reporting form; in long-term facilities, the form is done monthly. The form provides names of all the consumers, dates of admission, whether the person is a class member, whether the person is a MaineCare recipient, anticipated move out date, and whether there is a waiting list. Ms. Harrison and the QI manager review these forms. The QI committees receive the number of people served but do not receive the numbers of people served with and without Medicaid.

***86** Ms. Harrison has contact with residential services to try to find out what is going on. She meets with the agencies and she does a site visit if there is a change of service. For example, Chesley Street in Westbrook had a change. Six months after the transition, the Department performed a quarterly review with the CDC, QI, Director of Development, a consumer affairs representative, and Ms. Harrison. There is a CDC on the QI team and the CDCs are asked to participate in reviews.

The rate setting is calculated based on staff, the number of beds, the bed/day cost. They figure the agency cost formula on number of staff and number of residents. If a resident requires far more intense level of services, they can bring in additional staff for a period of time. In the formula, they anticipate some additional cost for additional support. She approves the rates and sends them to central office and then to the Bureau of Medical Services. The rates are set for one year, but agencies are permitted to ask for a change. She did not know if there were any limitations on the number of times they can ask for a change. During the last one and one-half years, she has not received any applications for a change in the daily rate because of a change in the circumstances of a resident. Two and one-half to three years ago, she did. Additionally, cost settlements are done. A facility can get additional money or it can lose money.

The Department's 1991 plan raised issues regarding the residential treatment facilities. The plaintiffs did not consider this type of facility to be housing. Mr. Rodman decided that residential treatment facilities could be housing but he understood the plaintiffs' desire for flexibility. The plaintiffs made proposals regarding issues at the facilities. The Department responded in early 1992. Among other things, the Department agreed that the term of residence in a residential treatment facility would be guided by the ISP.

The next major issue arose in late 1999. The Department had developed a policy to define residential treatment and residential treatment facilities as short-term residences only. Mr. Rodman mediated an agreement and developed a new policy, which really was a reflection of the 1992 policy. The length of the stay in the residential treatment facility would be governed by the ISP and client choice. It was understood that services would be provided on a flexible basis to reflect the changing needs of the class members. Mr. Rodman's 7/6/00 recommended decision regarding residential treatment facilities provided that length of stay in such a facility would be determined through the ISP planning process. *See* Jt. Ex. 30. This decision was not appealed but clearly has not been followed.

Initially, there were eight residential treatment facilities that were PNMI-funded. These were intended to accommodate individuals from AMHI for whom services would be flexibly provided. Two or three of those individuals are now proposed for supported living services. *See* Pls.' Ex. 71.

***87** Residential support services and housing are defined independently in the Consent Decree. Housing is a structure and residential support services provide assistance to reside successfully in housing. Mr. Rodman reported to the court on several occasions that he did not believe that the Department was meeting its reporting requirements for residential support services and that the Department was "mingling" residential support services with housing. Mr. Rodman believed, and the court agrees, that Claire Harrison confused housing with residential support services when she defined residential support services as a structure or a residential treatment facility during her testimony at trial. For example, in recent compliance reports, items that Mr. Rodman considered housing-related, such as BRAP, were reported under residential support services but residential support services were not evaluated in terms of whether the services met class member needs. Although the Department has stated that it provides some in-home

supports and that the Department receives quarterly reports from providers, the Department has not assessed that information or supplied it to the Court Master to determine compliance with paragraph 97.

In-home support services were part of the Department's overall planning. In the 5/96 plan, the Department defined residential support services in a way consistent with Mr. Rodman's interpretation of the Consent Decree and included a variety of in-home supports such as assistance with activities regarding daily living, emotional support, homemaker services, and personal care attendants. Since that plan, the Department has not reported these services consistently and independently, including in the Department's most recent report. Accordingly, the Court Master has been unable to evaluate the adequacy of residential support services provided by the Department.

Ms. Smyrski's responsibilities includes oversight and monitoring services on a regional basis and includes five state facilities: AMHI, BMHI, Freeport Town Square Immediate Care, Elizabeth Levonson Center for Children, and the Presque Isle-Aroostook Residential Center. She is responsible to lead and direct systems operations, including the regional offices the five facilities. *See* Jt. Ex. 2. She has had this job since 11/7/01. She has been employed by the Department since 3/82.

She testified about the Department's efforts, which began two and one-half years ago, to design responsive, high intensive residential programs for AMHI lengthy-stay patients. These individuals had common needs and the focus was on a successful integration into the community. The Department focused on four cadres of individuals. For major mental illness and co-existing medical conditions, the Department developed a six-bed program in Sabattus run by Tri-County Mental Health Services. The contract with this facility restricts placement to patients from AMHI. For dual diagnosis, which is major mental illness and co-occurring substance abuse, the Department developed Riverview II on the AMHI grounds, run by Motivational Services. For psycho-social rehabilitation, the Department developed Riverview I. This is a six-bed facility on the AMHI grounds run by Motivational Services and is designed for people who need to develop social skills. The Sawyer Street residence in South Portland is a six-bed facility for women. This facility is based on the TREM model because many of the women have a history of trauma. *See* Jennings Testimony. Sawyer Street is run by the Volunteers of America. There is one vacancy at the Sawyer Street residence; there are three or four referrals being considered by AMHI staff and Volunteers of America for this one opening. Beech Street in Saco is a six-bed facility. This facility houses all males except for one female and is run on a psycho-social model. *See* ¶¶ 86, 86c, 93, 95, 98.

***88** According to Ms. Smyrski, the original plan called for two, eight-bed units and that the Department "far exceeded the original plan" because they now have twenty-eight beds. *See* Defs.' Ex. 52; *contra* Jt. Ex. 1, p. 53. On crossexamination, she agreed, however, that the Beech Street and Sawyer Street homes were group homes and previously had contracts with BDS for twelve beds so these are not new beds. There are, therefore, sixteen new beds.

The funding mechanism for these SLS facilities is PNMI. *See* Defs.' Ex, 52 (funding, 7/1/02-6/30/03). There is a difference of opinion regarding what can be done in terms of reimbursement for ancillary therapy while a person resides at a PNMI residence. Defendants' Exhibit 97A is a plan for which she was responsible. When asked why the plan was revised, she said the initial plan was dated January or February, 2001 and provided that the facilities would be operational in June, 2002. The Court Master required more expedient action so the dates were changed.

The parties stipulated to the opening dates for these facilities. *See* Jt. Ex. 31. As of 1/25/02, the only beds occupied in any of these facilities were at the Sabattus facility. When asked what happened in 2001 and 2002 to develop these homes that could have not been done earlier, Ms. Smyrski testified that previous attempts in the system did not work. She denied that the impetus was that the Department finally thought about the issue. Although only one of these facilities was open as of 1/25/02, the defendants rely on this testimony to show compliance.

Although Ms. Smyrski urged the Commissioner to file the notice of substantial compliance, she did not specifically discuss the time frame of the plan for SLSs with the Commissioner. The plan called for "occupancy of new programs" in December, 2001. *See* Defs.' Ex. 97A; *see also* Defs.' Ex. 97. Ms. Smyrski did not discuss the plan with the Court Master in December, 2001 or before 1/25/02, when she knew that deadlines in the plan would not be met. She could not think of any information given to the Court Master after April, 2001 regarding progress being made on the SLSs.

Thomas Ward has worked at Bancroft Neurohealth since 12/01. Until recently, Bancroft provided residential support services for people with mental illness and mental retardation. Technically, three homes remain but the agency has decided to get out of this kind of work. The official transfer of these homes to another provider will occur within two to three weeks after the date of his testimony.

At the time of his testimony, there were two homes in Lisbon Falls for people with mental illness and class members resided in both homes. Mr. Ward is the area supervisor. He oversees homes and has daily contact with clients and participates in treatment team meetings. His

responsibilities included complying with licensing requirements, staff training, and budget supervision. He attended all treatment team meetings, reviewed incident reports, met with the staff as necessary and was available to clients at any time. He had contact with agencies with which the Department had contracts.

***89** There are two residents in the Plummer Street home and three in the Summer Street home. *See* Pls.' Ex. 56 (Summer Street residents). Both residents of the Summer Street home were under guardianship; one was a ward of the State and one had a private guardian, a family member.

It has yet to be determined whether these homes were licensed in 12/01. *See* Harper Testimony. The homes were licensed but an investigation was pending regarding staff complaints made in the late summer, 2001. The complaints included documentation, the physical structure of the homes, failure to follow procedures regarding contacting psychiatric services, misuse of funds, and verbal and emotional abuse of the residents by the staff. The complaint involving the failure to get psychiatric services resulted from two or three incidents in which residents had allegedly threatened suicide and crisis services were not called.

Mr. Ward attended an ISP meeting regarding patient # 1 at the Summer Street residence in late January or early February, 2002. *See* Pls.' Ex. 56. This patient did not have a CSW or a worker from another agency. Mr. Ward developed a plan for the patient and his needs were identified, except for services provided by the home and tried to get a CSW for the patient. In the spring, 2002, he had discussions and meetings with the Director and supervisors at Tri-County to determine why this patient and others had no CSW. Mr. Ward was informed that a CSW or case manager was not a possibility because case management is limited to medical case management or medication. Mr. Ward was told that other people had a greater need for case management services and that there were insufficient resources to provide services to this patient. As of the summer, 2002, this person still had no case manager.

This patient wanted to have a job and relocate but had previously been denied vocational rehabilitation. The public guardian was going to reapply or find another alternative. The guardian was involved in deciding where this patient would live and she was involved in his vocational goal. He had tasks to accomplish before he reached that vocational goal but he was capable of doing those tasks with help.

From 12/01 through 6/02, the patient did not receive vocational rehabilitation services. Neither Mr. Ward's agency nor Tri-County took responsibility for getting this patient vocational services. As of June, 2002, he was not getting services. The patient also wanted to move back to Rockland, where he grew up. As of 6/02, he was still residing in the Summer Street home in Lisbon Falls..

Patient # 2 resided at the Summer Street home in 12/01. Mr. Ward had contact with this patient through conversations, ISP meetings and reviewing records. This patient had a private guardian. The CSW from Tri-County did not attend ISP meetings at the home; if meetings were held some place else, Mr. Ward did not receive notice.

The first planning meeting for this patient took place in February, 2002. As of summer, 2002, the patient was not receiving services from any agency; he received his medicine from a psychiatrist through Tri-County. He had no case manager. When Mr. Ward requested comprehensive case management services for this patient, Tri-County made clear that the services would be limited to medication. Tri-County assigned a case manager for his medical needs but made no efforts with regard to other case management services.

***90** The testimony of the defendants' witnesses establish non-compliance with these paragraphs. The testimony of Mr. Ward, Mr. Rodman, and the class members whose services were terminated or whose services were not appropriately delivered confirm non-compliance.

D. Crisis Intervention and Resolution Services

Ms. Smyrski was the Director of Crisis Services from 1989 through 1996. In 1996, there was a structure change in the Department's crisis services and the state programs were privatized. The five components for the crisis plan are listed in the 5/96 implementation plan. *See* Jt. Ex. 1.

In Region I, which includes Cumberland and York Counties, the Department contracted with two major providers. In Region II, which includes Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo Counties, the Department contracted with four major providers. In Region III, which includes Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties, the Department contracted with three major providers. *See* Defs.' Ex. 56B (7/1/02-6/30/03).

Ms. Smyrski's current involvement with crisis service is systemic through several organizations and groups. In the fall, 2001, she chaired the CLASS committee. She is the co-chair of the Initiative Group and she attends the Department's team leaders meetings for discussion of crisis services and in-home support.

Crisis residential beds in the state are located in the Aroostook Mental Health Center, Community Health and Counseling Services in Bangor; Crisis and Counseling in

Skowhegan, Waterville, and Augusta; Rockland Mid-Coast Mental Health Center in Rockland; NAMI of Maine in Rumford; Tri-County Mental Health in Lewiston; Sweetser in Brunswick; Ingraham in Portland; and CSI in Saco. *See* Defs.' Ex. 55. The contracts reflect funding projected amounts for fiscal year 2003. The funding comes from the general fund and Medicaid and Medicare funds. The designation "N/A" on defendants' exhibit 55 indicates that only in-patient hospital beds and not community crisis beds are provided.

According to Ms. Smyrski, the Department ensures compliance with paragraph 99 by providing all crisis services through contracts with community agencies with the exception of three state employees in York County. Ms. Smyrski testified, once again, about "expectations ." She stated that there is a "clear expectation" that the requirements of subparagraphs of paragraph 99 will be met. This testimony was not relevant and was non-responsive to the Department's attorney's question about what the Department does to assure compliance. After twelve years, the court is interested in accomplishments and not expectations. This testimony from Ms. Smyrski about expectations is not summarized.

According to Ms. Smyrski, the Department determines if these "expectations" are being met through the quarterly contract review meetings, review of the contract requirements during licensing visits, and feedback from clients, family, and providers. She alleges that she has not received complaints regarding crisis for more than a year, although she does receive complaints regarding other components of the system. Further, performance indicators regarding paragraph 99 issues are submitted by providers on a quarterly basis. These show if there "are trends" or consistency. Periodically, she reviews performance indicators. The annual class member survey findings are reviewed. The performance indicator data and the class member survey findings data are discussed with the regional staff and they "dig deeper" to find out what is happening.

***91** The performance indicators show the number of bed days and the occupancy rate. From that, she testified that you can tell capacity. She agreed, however, that an agency's report of 75 bed days and 80% occupancy would not permit a determination of the number of days the unit was operating at capacity. After several questions, she finally agreed that the Department does not review the number of days that the crisis residential units are at capacity.

She discussed in-home crisis supports with the mental health team leaders. She has requested that mental health team leaders look at this component and make recommendations regarding effectiveness and changes to be made with regard to ongoing feasibility. She has received a recommendation from Region I. Some action has been taken by the Department to assure that short-term in-home crisis supports are available but not long-term. In-home crisis supports should not be available for non-acute problems, according to Ms. Smyrski. No other action taken as a result of this issue.

The Commissioner approved the crisis standards in April or May, 2002. These standards will be incorporated in the next round of contracts. *See* Defs.' Ex. 60 (dated 5/31/02). The Department has not previously tracked transfers from emergency rooms although that tracking had just started at the time of Ms. Smyrski's testimony. The Department has not decided if that provision will be added to the contracts with hospitals with which they contract.

Thomas Lynn has been the Assistant Director of Children's and Crisis Programs at CHCS in Bangor since 1999. His current responsibilities include administrative and clinical responsibilities for the project, and overseeing a staff of five clinical supervisors, 21 mobile crisis workers, and nine crisis residential direct service workers. This organization operates mobile teams in Penobscot and Piscataquis Counties for children and adults in crisis.

CHCS has three direct service departments, which include adult mental health services, therapy, psychiatric, group homes, and apartments with various levels of support. An organization in Machias, the Washington County Psychotherapy Associates (WCPA), operates mobile and phone services for Washington and Hancock counties under a separate contract. CHCS works with the WCPA.

The CHCS contract with the Department provides approximately 90% of the CHCS funding. The remainder comes from third-party insurance, self-pay, and grants. He requested from the Department an increase in funding for an additional one-half time crisis worker during the twelve months prior to the date of his testimony.

The minimum qualification for crisis workers is MHRT II or C, which is the same qualification required for the CSWs. In other words, the front-line responders have the minimum qualifications. Six or eight of the crisis workers at CHCS have an MHRT II and no additional licensure but those MHRT IIs have extensive experience in the field. Some workers have a Masters degree and some are attending classes for a degree. One mobile worker has a nurse practitioner's license.

***92** New employees are given core training that involves client rights, CPR, and OSHA requirements. The crisis workers are trained for one and one-half or two weeks in the requirements of the Consent Decree, community resources, assessments, crisis and planning, and the family system. New crisis workers shadow other crisis workers before beginning work. They then reverse shadow. The supervisor decides when the person is ready to begin work and the type of work for which the person

is ready. There are some annual recertification requirements, such as CPR. College courses, workshops, and the annual crisis conference are available. Training from the consumer perspective is done by a member of the staff who has mental health issues.

The crisis training curriculum dated April, 2002, was described by Mr. Lynn as "a real improvement." *See* Defs.' Ex. 61. This exhibit is a draft and not the finished product. When it comes back from the editor, they will try it out.

During the spring, 1996, the Department issued an RFP to develop comprehensive services, including phone and mobile services for four of the five counties in Region III. Provision of services began in the summer, 1998. CHCS has a six-bed CSU in Bangor, which includes two double and two single bedrooms. Two direct service people are present twenty-four hours per day and admissions are accepted twenty-four hours per day. Daily clinical assessment and support is available, as well as case management and the opportunity to link with longer term services. The average stay in the CSU is three and one-half or four days.

Mr. Lynn described the CHCS procedure. A person must be eighteen years old, must be a voluntary admission, and must agree to abide by house rules and to maintain his own safety in order to be admitted to the CSU. Previously, other inflexible eligibility requirements were in place. In an effort to serve their clients better, the CSU now admits people who are at greater risk with a wider range of medical needs. The CSU also provides step-down from psychiatric hospitals and provides transition from the hospitals to the community. This enables clients to move out of a more restrictive setting and to stay at the CSU as long as required. According to Mr. Lynn, the hospitals, particularly Acadia, do not always do adequate discharge planning and the community health crisis services have to start from scratch, which extends the length of stay for the client. CHCS has informed the Department of this problem and has had meetings with Acadia.

CHCS has worked to develop a step-down program with the Mid-Coast Hospital and Acadia, primarily, but CHCS serves psychiatric hospitals all over Maine. The step-down program began in the spring, 2002. Packets of information about the program have been sent to all of the psychiatric hospitals. CHCS is reaching out to PenBay, Spring Harbor, and BMHI. The majority of CHCS's step-down clients come from Acadia but some also come from BMHI, Spring Harbor, Maine General, and PenBay. The hospitals are licensed by DHS; CHCS is licensed by the Department. Both licensing agencies ask CHCS to follow up in writing regarding admissions. The average stay for the step-down clients at the CSU is one or two weeks but it is too early in the program to accurately predict the average.

***93** Initially, the CSU was filled 50%-60% of the time. After outreach, the units are still not full but since March, 2002, they have averaged 85% utilization. CHCS decided to take no more than three step-down clients because step-down is secondary to regular intake.

CHCS distributes cards with a statewide crisis number and the calls to that number are routed to the appropriate facility in the caller's area. CHCS has a toll-free number for support and to discuss issues of concern for use by clients and family. This is called a "warm" line because it is a non-crisis line. When crisis calls come in on this warm line, they can be automatically switched to the Phone Help line, which is the crisis line. The warm line is staffed by a volunteer; one staff person recruits the volunteers. A toll-free support line called Phone Help is available and most calls come through Phone Help. During the telephone call, an assessment is done of the reported need and a determination is made whether the person requires a face-to-face contact through a mobile unit. If so, the mobile worker is called and information is given to the worker with the client's permission. The mobile workers either call the client or meet with the client if the call is from an emergency room.

Most face-to-face visits between clients and crisis workers occur in the emergency room, which Mr. Lynn agrees is not the best place to do a face-to-face interview with crisis providers. CHCS tries to find a way to discourage sending clients to the emergency room but most primary care doctors tend to refer to the emergency room.

The procedure involves the mobile workers talking to the client for a few minutes to several hours. If the worker determines that face-to-face contact will be helpful, the worker meets the client. When they do meet with the client, they do a psycho-social crisis assessment of the client and develop a crisis stabilization or treatment plan that complies with licensing and the worker can offer services to the client. The worker and the client develop a pro-active safety plan that is similar to an ISP with the same format and that includes everything from hospitalization to other services in the community, the phone line, employment, Medicaid, follow-up visits, giving permission to CHCS to contact other providers, considering natural supports if the client is not stable in his current residence, and the CSU.

The mobile workers on face-to-face visits have twenty-four hour clinical backup through pagers. The clinicians answer questions, help with assessments, and review the crisis plan to make sure all available options have been considered. Mr. Lynn stated that "crisis is contagious." The workers have twenty-four-hour access to a psychiatrist and crisis workers are available at any

time.

After receiving a call from the hotline, the time required for a worker to reach a client varies, depending on distance. The average time is under an hour. Data on this issue are included in the quarterly reports sent to the Department.

***94** After the stabilization plan is finished, the client signs off and the client is transported to where it is agreed he will go. The worker helps with other needs, such as food. A follow-up visit, either by phone or face-to-face, is scheduled,

CHCS almost always offers the client the opportunity to go to the CSU. If for some reason the client cannot go to the CSU, other options are sought. The worker can take a person to a motel if the person has no safety issues. If there are safety issues, someone will stay with the person, including professional support systems or professional staff. Mr. Lynn previously developed protocols to hire professional staff but received no interest. Accordingly, CHCS uses mobile workers or other staff to stay with clients who need support.

If the client is taken to the CSU, a plan for the stay is developed. The client signs the house rules and is admitted. If the client changes his mind, other arrangements are made. Upon admission, the direct service staff takes over. Within twenty-four hours, an assessment is done and an assessment is done every day thereafter by the clinical manager of the unit. Assessments are done by mobile workers during the weekends.

CHCS tries to support the client but tries not to make the client too dependent on the CSU. It is sometimes difficult for these clients to leave. Generally, a joint decision to leave is made, although sometimes a client will refuse to leave. CHCS then spends several days discussing this issue; sometimes law enforcement is called as a last resort.

Discharge planning is put together to reflect the client's goals while at the residence and to incorporate long-term goals. Releases are renewed and plans for follow-up in the community are discussed. The cards for CHCS are given to the client. If the client already has a CSW, CHCS will obtain a release and inform the CSW where the client is or will invite the CSW to the CSU. If the client wants a CSW and meets the requirements of outreach and no CSW is available, an ICM will talk to the client.

The lease has expired on the current CSU. CHCS wants a new CSU with more individual rooms. Based on the Initiative Group information, the best practice is six beds for a staff of two direct service providers at one time. In order to increase the beds, CHCS will need more staff. Geography may suggest that two six-bed facilities make sense. CHCS has turned people away from the CSU.

If CHCS receives a call involving a serious situation and the client is some distance away, CHCS confirms first that the client is safe. If not, CHCS looks to family, neighbors, friends, law enforcement, EMS, and the emergency room. CHCS prefers not to involve law enforcement, but law enforcement will be called if the person's situation is dangerous and the person cannot maintain his own safety. The police may be involved if the person lives in a remote area, is intoxicated, or has guns.

As noted, there are no formal in-home supports as part of the CHCS crisis program. CHCS asks people who are currently not working to take care of this need. Mr. Lynn agreed that in-home supports are important to stabilize certain clients who want to remain in their home, although he stated that giving in-home supports to people with a history of trauma sometimes can be counterproductive. He said that one-half to two-thirds of the five or ten high users of the CSU have a history of trauma. He agreed that the decision regarding in-home supports is best made on an individual basis.

***95** Under the contract with the Department, quarterly reports prepared by Mr. Lynn are filed that document the number of contacts, the number of unique clients, and the number of face-to-face contacts. The numbers of crisis contacts and telephone contacts in Region III far exceed those numbers for Regions I and II. *See* Defs.' Ex. 64.

During July, August, and September, 2002, 500 face-to-face adult clients were seen. There were 2,000 telephone contacts for that period. CHCS also receives calls from people other than clients, including family, providers, friends, shelters, emergency rooms, and law enforcement.

He estimates the number of repeat clients to be 30%-60%. There is a core group of clients whom CHCS serves on a regular basis. These clients are discussed during their weekly discussions. They ask if they can meet with these clients and their providers to see what additional things can be done in order to respond more appropriately when the clients return.

CHCS has written agreements with the hospitals it serves. The emergency rooms call the Phone Help number or request that workers go to the emergency rooms. The mobile workers go to the emergency rooms and speak to the medical staff. The mobile workers recommend to the ER staff at the hospital that the person can go home, can go home with friends, should go to the CSU, or should go to a psychiatric hospital. The CSU is called if there is a substance abuse problem because it is difficult to determine whether substance abuse is the primary problem. For Mr. Lynn, the issue is whether the person

can make a sound decision at that time and not whether the person has a certain blood-alcohol content.

Often the patient will raise the possibility of hospitalization; sometimes CHCS raises the issue. If admission to a psychiatric hospital appears appropriate, that alternative is discussed with the client. If the client agrees to admission, the particular hospital is discussed. According to Mr. Lynn, federal regulations require that CHCS seek the nearest geographic psychiatric hospital for the admission. If the client does not want to go to a particular hospital or if the client prefers a particular hospital, the worker consults with the doctor or the PA, calls the psychiatric hospital, makes a presentation, and waits for a decision. The hospital's decision is made within fifteen minutes to one and one-half hours or longer. AMHI is on the list of potential admissions, but he did not know how often clients go to AMHI.

If the hospital agrees to admission, the worker informs the client and waits for the ambulance to transport the client. The crisis workers can stay with the client if the client desires that although sometimes they are called away on other assessments. Previously, the workers tried to use the least restrictive ways to transport a client to the hospital, including transportation by the mobile workers or by family. Mr. Lynn understands federal law places responsibility on the hospital for the person's safety during transportation to a psychiatric hospital. The client can sign off and waive the ambulance. His staff may try to pursue less restrictive modes of transportation but the staff is consistently overruled because there is vigorous enforcement of these federal laws in Maine. He agreed that recommending appropriate transportation should be part of the emergency room protocol.

***96** The hospital wants to know if the person is "medically clear" before admission. Most of the time the emergency room takes care of the medical clearance issue. A psychiatric hospital can agree to admit a patient without an emergency room examination if the hospital knows the person well.

If the client is unwilling to go to the hospital, the worker considers involuntary hospitalization if there is imminent danger to the client or others because of mental illness. The worker proposes to the medical staff that hospitalization is needed and that papers should be prepared.

CHCS asks clients if they are willing to complete a survey. The CHCS contract with the Department requires surveys but not a specific number of surveys. The surveys must be completed only by clients willing to complete the surveys. Through the Initiative meetings, he has seen the Region III data for crisis but he was unable to comment on whether there were any trends during the previous twelve months. Information from the surveys is recorded on the quarterly reports sent to the Department. If a name and address is listed on the survey, CHCS calls the clients or sends them a letter. Mr. Lynn asks the emergency rooms in the area to inform him if they hear any concerns about CHCS. At their meetings, they review clients who are more active than others and have meetings with the treatment team or other providers.

Mr. Lynn attends meetings with other crisis providers to discuss the system. He also attends the Initiative Group, which includes crisis providers, the Commissioner, staff, and emergency doctors. This group discusses a variety of things, including crisis curriculum for crisis programs, medical clearance, and blood-alcohol content. He believed that consumers had attended that meeting but he was not positive. Representatives from NAMI have attended. He has seen changes in the crisis service system resulting from the Initiative Group, including medical clearance guidelines to help them understand the need for testing.

The last quarterly report for July through September, 2002 was submitted in October, 2002. The emphasis now is on decreasing the number of inappropriate hospitalizations. These numbers rise in and fall each quarter In 1999, 20% or 25% of all face-to-face meetings ended in psychiatric hospitalization. At the time of his testimony, the figure was 12% to 18% and the average is 16%. During the quarter prior to the date of his testimony, this figure rose to 24%. He wanted to find out why this happened and whether this represented an unusual fluctuation or something they are doing or not doing. The previous two quarterly reports showed hospitalization figures in the 12% to 18% range. He has spoken to all the supervisors and they will go through a random sample of the records.

Mr. Lynn was asked whether since 1/25/02, the Department had asked him to report indicators other than the usual. He said that every contract year, indicators tend to change and he would have to compare documents to determine whether there were different indicators this year. He did not know if the Department was requiring new information.

***97** Leslie Mulhearn is the Director of Acute Services at Mid-Coast Mental Health Center and she is in charge of the access department, CSU, and mobile crisis team. She had had this position for four years and had been at the agency since 1994. She oversees services, including licensing requirements, complaints regarding services, and staff training and monitoring. Her Region includes Knox and Waldo Counties and Waldoboro. Mid-Coast has offices in Belfast and Rockland.

Mid-Coast is one of the smaller crisis providers. It is funded by a grant from the Department; Ms.Mulhearn did not know the figures for Medicaid, self-pay, or private

insurance. There are thirteen full-time equivalents, a mobile and hotline service, and a two-bed CSU. The CSU is in Rockland and is utilized approximately 65% of the time.

All clinicians have a minimum requirement of a MHRT-II or C license and an LSW license. They have at least a B.A. degree in related fields, some have a Masters degree, and some have independent licenses, such as MSW or LPC.

The agency orientation requires one day to complete. The review includes RRMHS, hospital procedures, what it means to be a crisis clinician, what it means to be a client, and how to manage a system that is in crisis when you enter it. New employees shadow other workers for one week and then do reverse shadowing. During the first year, there is an additional 40 hours of training required, based on their needs. The five MHRT-I people have 40 hours of training, read materials, and have on-the-job training. She agreed that the ideal level of training for front-level people would include a background with diverse experience, training, and the ability to manage crisis.

Ms. Mulhearn described the crisis procedure for Mid-Coast. Mid-Coast provides twenty-four-hour per day access to a psychiatrist and an independent licensed clinician. The psychiatrist reviews the clinical case and the independent licensed clinician takes questions regarding procedure.

Mid-Coast is subject to the Department's licensing requirements. The most recent license review began during the fall, 2002 and was underway at the time of Ms. Mulhearn's testimony in November, 2002.

Clients access Mid-Coast by calling directly and by walking in when Mid-Coast is open. Emergency rooms call Mid-Coast for crisis intervention and Mid-Coast responds. Mid-Coast receives calls from schools, families, neighbors, and police. Mid Coast does outreach for individuals. Mid-Coast has had a warm line for three or four years, which is not a part of crisis services. The caller on the warm line can be given a crisis worker.

Ms. Mulhearn does not refer to discussions with the clients as evaluations; they are intervention services to help the client move through the crisis. In the majority of cases, the client can return home. There is sometimes a wait list for outpatient therapy, which is difficult to access. Sometimes the person requires a different level of care, such as friends or parents to stay with him, or admission to the CSU, or hospitalization. The emergency room doctor has the final say in the emergency room but Ms. Mulhearn considered this a collaborative effort. The crisis workers discuss the case with the on-call psychiatrist and present their decision to the emergency room doctor. In general, the emergency room doctor agrees with their assessment.

***98** If the client is going to be hospitalized, they defer to the client's preference for a hospital. If there is no preference, they discuss the hospital closest to the client's residence and then discuss hospitals farther away. They do not use a hospital the client does not want unless there are safety risks in not using that hospital. They track the time from receipt of the call to the arrival of the worker. If hospitalization or use of the CSU is not necessary, they offer the patient outpatient therapy, a psychiatrist, community support, and follow-up by the crisis clinician.

The crisis worker can suggest involuntary hospitalization but the emergency room doctor makes the decision. According to Ms. Mulhearn, transportation whenever possible is done according to the client's choice. Travel can be done by a family member, crisis worker, or a emergency service worker, although an ambulance can be used for safety.

After the initial intervention, an acute service plan is developed before the end of the contact The client and the clinician decide what follow-up, if any, will occur. At a minimum, the crisis telephone number is given to the client and at a maximum, a series of follow-up meetings or calls are scheduled. An acute treatment plan is also done for hospitalization and the client receives a copy in case he later does not recall the circumstances of the crisis situation. Every intervention includes an attempt to include other providers. CSWs are called and attend if available; they are told what has happened if they cannot attend. The CSW then is responsible to tell any other providers about the crisis and the outcome. Mid-Coast is required to get releases to speak to any providers not in its system. A copy of the intervention is sent to the providers with the client's permission.

Mid-Coast's two-bed CSU has been used as a step-down facility for one and one-half years. It is used two or four times per month. Any hospital in the state can use this CSU. She believed the utilization rate for the CSU was 75%; at the time of her testimony in November, 2002, the rate was 65%. There is no written protocol for the step-down program with hospitals. When the hospitals call, Mid-Coast faxes information the performance reports.

The CSU does turn people away because the unit is being used as a step-down facility. That scenario had occurred within the past year but she did not know how often. Mid-Coast does not maintain a specific number of beds for the step-down program. Clients are turned away from the CSU if they are not medically stable, if the CSU is full, or based on considerations on the unit. Such considerations do not always involve gender; the issue is whether two people can be stabilized in the same unit. If a

client is turned away from the CSU, Mid-Coast considers another CSU. Mid-Coast also considers what is required to get the individual through the crisis and that may be hospitalization.

She said that when a client is hospitalized away from home it is very difficult for that hospital to connect with services in the community. She did not know the reason for that problem.

***99** Mid-Coast does not provide in-home support services. If in-home supports are needed, they develop a plan for natural supports or the CSU. She thought they might have discussed in-home supports at the Initiative Group but she did not recall. She agreed that in-home supports are part of the recommended standards. She has not tried to implement in-home supports and has not asked the Department to do a pilot project. Similarly, no one from the Department approached her to do a pilot project.

Mid-Coast evaluates its crisis services through twenty surveys sent monthly to people who use their services. Although she stated that she sends twenty surveys per month, she agreed that that statement may not be correct if the CMA shows that thirty surveys are sent per quarter. A very small percentage of the surveys are returned, from one to five. She agreed that this was an area in which Mid-Coast needed to improve. Mid-Coast is trying to develop a better survey tool but this has not yet been done. Mid-Coast received a standard survey tool from the Department a few weeks prior to her testimony in November, 2002.

Ms. Mulhearn also attends community meetings for feedback. She participates in the CLASS group, which includes directors of crisis services, managers of crisis services, some hospital people, and regional medical directors. Mid-Coast receives information from the Consumer Advisory Board and its Board of Directors. Anyone who calls with concerns about crisis is offered a meeting by Ms. Mulhearn.

Data are collected but she was not aware of the statistics for Region II in general. Mid-Coast prepares quarterly reports for the Department, which she reviews. Mid-Coast has developed performance indicators and will be evaluating them.

She thought that the Department might have requested that Mid-Coast report during 2002 on an indicator specific to a population of people over the age of 60. Mid-Coast is not required to report the number of days at capacity in the CSU. They report CSU days available and days used. She was asked whether she reports patients receiving non-acute care but who meet acute care criteria; she thought the language was familiar.

She did not know the number of people who had crisis plans who called MidCoast. She said that during the ISP process, a crisis plan is developed with the crisis clinician. She was surprised that only 14 out of 520 face-to-face contacts had established crisis plan. She reports data on how often an established plan is used but not how many clients have an established crisis plan. Some members of her team misunderstood what was meant by that requirement; the data written did not make sense to the team. In any event, she does not know if the data are accurate and she does not specifically follow up and look at the data.

Ms. Mulhearn has a personal mark of less than 20% percent hospitalization. If the percentage exceeds 20%, she does a search to find out why. The last three quarterly reports show a hospitalization rate of not more than 20%. She decided to use the figure of 20% because the "average data over time" has shown her that if the hospitalization rate exceeds 20%, "something is wrong." The Department provides no benchmarks for any the areas she reports on. She determined that 20% hospitalization rate mark made sense for them internally based on their experience over time. There is an very small shelter in the area, which results in more opportunities for hospitalization.

***100** Mid-Coast's internal policy requires that all complaints are written up. The complaints are accumulated and a written report is sent to QI at Mid-Coast. Files are reviewed to see if needs are met. She did not know the number of files reviewed; they looked at fifteen or twenty files last fall.

For the quarter January through March, 2002, Mid-Coast had 1729 contacts from clients. The clear majority are telephone contacts; face-to-face contacts are about one-third of the total. From July through September, 2002, there were 500 to 700 face-to-face contacts and more than 1000 telephone contacts from clients served by the crisis program. The percentage of two or more face-to-face interviews for the same person was 30% for the summer, 2002. She reviewed this data but she did not know why she reviewed it. She testified initially that the percentage of face-to-face contacts in which a psychiatrist was actually called exceeded 80%. She then changed that testimony and said that number does not reflect psychiatrists actually called but just consulted.

A significant amount of the face-to-face contacts occur in the emergency room; more occur in the emergency room than in any other place. She said no one has said that was a problem and the use of the emergency room for face-to-face interviews in Region II was not a topic of discussion during the past year.

The Initiative Group met monthly for more than a year. The group developed committees in order to improve the

system. She was a member of the standards committee and the crisis clinician training committee. The standards committee developed standards for crisis services and eventually these standards were incorporated into the contracts. She found that there was a need to add many more standards than were required by the national group. Defendants' exhibit 60 is a document they developed. It is dated April 1, 2002. *See* Defs.' Ex. 60. The document was sent to the Department.

Defendants' exhibit 62 is the medical clearance protocol. This document is also dated April 1, 2002. *See* Defs.' Ex. 62 (admitted for the fact that her agency follows this protocol, which was developed by the Initiative Group was submitted to the Maine Hospital Association). She supported this protocol because there were delays in service. This document was submitted to the Maine Hospital Association. As far as she knew, this protocol is followed in the emergency room.

During the past four or five years, the Mid-Coast crisis staff has increased by five full-time equivalents. Mid-Coast requested another clinician and received the position in June, 2002. The request for that position was intended to reduce response time. Training is provided in trauma and response to people in crisis with a history of trauma. Mid-Coast has what is called a front door/back door meeting, which is intended to make going into the hospital and transitioning out of the hospital a smoother process. These meetings are to be attended by the hospital psychiatrist; MCMH psychiatrist; social workers, nurses, directors from the psychiatric units; managers; and Ms. Mulhearn. At times, they invite clients.

***101** Since January, 1999, Jennifer Goodwin-Alley has been the Program Director for Crisis Response Services (CRS) at CSI in Saco. Her Region is York County. CSI provides support workers, group homes, ACT Team, dual diagnosis and substance abuse services, social clubs, life enrichment program, and outpatient offices. The crisis services and two ACT Teams are located in Biddeford.

She described the CRS core programs, which are the same as those described by Thomas Lynn and Leslie Mulhearn. The program is a 24-hour program with phone access. An assessment determines the appropriate level of care on a follow-up basis. They have an additional program for stress management to deal with community kinds of tragedies resulting from suicides, deaths, robberies, and similar events. The same staff handles this program. CRS does not have a warm line. Ms. Goodwin-Alley was not sure why that was true and did not know if one was recommended to them. The Department has not required a warm line and CRS has not asked for funds for a warm line.

CRS has 23 full-time equivalent positions for crisis workers but 35 people fill these positions. Nine of those employees have only a MHRT II or C. All mobile crisis team member have a minimum MHRT II or C. The orientation provided is similar to that discussed by Mr. Lynn and Ms. Mulhearn. Training includes a class, individual supervision, and job shadowing. Continuing education for employees is offered.

She agreed that minimum training was provided for the front-level people and that the front-line crisis workers had one of the most difficult jobs in the mental health system. Ideally, these would be highly experienced, fully licensed people. She has not requested in the last twelve months that the Department try to increase the qualifications for front-line work. Although she perceived that it was out of the Department's control to change the employment market, she agreed that it was not out of the Department's control to increase salaries.

Funding comes from state grants, Medicaid, insurance, self-pay, and a small amount from the United Way. Medicaid reimbursement is crucial to her program.

She does not do chart reviews. The supervisors do four reviews each month. From "a couple hundred" charts per month, sixteen are reviewed. When charts are reviewed by the supervisors, the clients are not contacted.

The data on the quarterly reports are used for goal review; if the numbers are not sufficient and they are not doing an adequate job, they talk about what the numbers mean and what to do differently. The Department has not provided benchmarks for categories reported on but there is "an expectation, according to her supervisor," that mobile crisis assessments will exceed 20% of the services they deliver. With regard to other categories, they go by "our own indicators" to determine if something "seems high or low."

Ms. Goodwin-Alley does not operate the CSU in Saco but her program does all of the screening for the CSU. CRS has mobile workers, a telephone line, impact team, and a SAFE (support assessment for families in emergency) program.

***102** Since September, 2001, the seven-bed CSU has been located in one unit in Saco. The unit includes five bedrooms. Requiring that clients share the same bedroom can complicate admissions but she is not limited to using the Saco CSU. The facility is used as a step-down but that use is infrequent because there is little need. She was not aware of a directive from the Department to use the CSU as a step-down facility but that there was a lot of discussion about the issue. This CSU has served as a step-down facility for patients from AMHI.

Before September, 2001, the agency had two CSU units with six beds in Saco and three or four beds in Kittery. These were consolidated because of client volume. Ms.

Goodwin-Alley agreed that it was probably preferable to have crisis beds in more than one location because of the size of York County.

Time periods when the CSU is at capacity are tracked. During the last quarter, the CSU was at capacity and could not accept people at times but she did not know how often that had occurred. The inability to accept people happens twice in any given week. If the CSU cannot take a client, the workers discuss the issue with the client and explore other CSUs, explore going home with extra family or other supports, explore partial hospitalization, which means in a program during the day and home at night, or explore full-time hospitalization.

The SAFE program is located in the Biddeford office. The program permits CRS to hold an individual for a period of time, usually a day, until an option is available. Approximately twelve people used the SAFE program during the last quarter. Sometimes another placement will not be necessary because CRS provides assessment and information during the waiting period.

The SAFE program is housed in a large room with handicapped access. CRS uses the SAFE program when a disposition identified as needed is not available or when it is not clear what should happen with an individual and when the individual does not present a significant safety risk. The workers can have a difficult time getting a hospital placement for people. When hospitals are full or have no capacity to accept clients, placement can take a "long time ." She stated that this issue has been raised with the Department and is a topic of discussion for the Initiative Group. According to Ms. Goodwin-Alley, no one feels "good or complacent" about this issue. When they determine that hospitalization is indicated, the client's choice is determined and they check the hospital. This SAFE program was started because, particularly in the children's area, there were significant delays in access to hospitals.

CRS tried to develop crisis in-home supports but there is insufficient staff and money. It was determined that in-home supports were not feasible for her program. The program did provide that service for one and one-half years but it was terminated in the spring, 2002 because the volume was insufficient to support one employee and it was very difficult to hire for this position. The employee provided 20 to 22 hours of service per week; in order to make the position feasible, the employee should have provided 29 hours per week, which is difficult in the context of a forty-hour week. CRS kept track of the number of clients and the number of hours involved with in-home supports; she did not recall these numbers.

***103** The in-home supports that were in place for one and one-half years were studied to determine whether the supports avoided or decreased hospitalization. She did not know if the report was given to the Department or whether the report was requested by the Department. CRS negotiated with the DHS Medicaid office to increase the rate for services in order to continue in-home supports but the effort was not successful. CRS negotiated throughout the entire period of use of in-home supports, through the termination, and after. CRS requested a fee of $100 an hour but $69.00 per hour was paid. The Department was notified when in-home supports were discontinued, she was unaware of the Department's response.

CRS has regular interventions on the crisis unit and the SAFE unit. Some of the clients are involved in community support programs with larger agencies. Follow-up is done with other providers to the extent that is practical. After hours, CRS has its own psychiatrist on call twenty four hours per day, seven days per week.

CRS's goal is to contact the client within one hour of a call, depending on the distance to the client but the actual time period can range from five minutes to a few hours, depending on safety issues and staff availability. The fewest staff members are on duty during the overnight hours, when there are two people on-call. The mobile worker cases are reviewed by a psychiatrist.

She agreed that sometimes the telephone workers and mobile workers instruct people to go to the emergency room. This is particularly true if safety is a consideration and medical clearance is required. CRS is responsible to work with callers to help them through a situation. If CRS succeeds, the caller can wait for the response; if CRS is not successful, the caller might be asked to go to the emergency room. CRS considers that decision seriously because the person will have to drive to the emergency room, although rescue is called on occasion.

According to Ms. Goodwin-Alley, CRS is able to stabilize 75%-95% of its clients without hospitalization; the hospitalization rate is, therefore, 5%-25%. The hospitalization rate typically is 16%-17%. The length of stay in a hospital in her area is reviewed only in the Initiative Group.

CRS has attempted to do surveys but they receive a very poor response. Previous surveys did not provide sufficient information to make a meaningful determination regarding concerns. CRS was not actively conducting consumer surveys at the time of her testimony. Feedback now comes from speaking to clients at social clubs, which are open to anyone with a mental health diagnosis, going to groups, and talking to clients, staff, and agency workers. The supervisors also review written documents, including face-to-face contacts and phone interaction notes. She had not seen the Department's new standard survey. She has not been asked to implement a new standard survey.

The number of phone contacts for the last quarter totaled 2,000; face-to-face contacts totaled 774; the actual number for unduplicated individuals was 180 face-to-face contacts. Although she stated that that number was a high number for her agency, the number of contacts was lower than expected. She did not know why CRS had 774 face-to-face contacts for the last quarter. Because CRS did not have any increase in staff, per diem staff was probably used. The percentage of face-to-face contacts that occurred in the emergency room was in the high 40% range, approximately one-half. She agreed that greatly exceeds the number of face-to-face contacts that occurred in the clients' homes. CRS maintains data for phone contacts but she did not recall the statistics. Generally, face-to-face contacts are preceded by phone contacts. After a face-to-face intervention, the mobile crisis worker is expected to document the intervention and the supervisor is expected to review the chart and sign off on chart.

***104** Ms. Goodwin-Alley and her program report on the number of contacts, number of phone contacts, number of face-to-face contacts, dispositions, waiting time, the location where the client is seen, and the location of choice. After the report, she becomes distracted running her program and then begins reporting on the next quarter's figures.

The Department performed a licensing review during the winter of 2001-2002. Staff and clients were interviewed and stacks of charts were reviewed. She was not aware whether the Department's licensing review assessed the need for services versus the adequacy of services.

Ms. Goodwin-Alley was asked by plaintiffs' counsel whether during the six months prior to January, 2002 there had been any formal review by the Department to measure the adequacy and quality of crisis programs. She said there was none. Her agency, including crisis, was reviewed a few years ago. If she could improve crisis response, she would speed up access to admission to psychiatric units, technology, and recordkeeping.

Ms. Pellegrini testified that Kennebec Valley's twenty-four hour telephone service was discontinued at the end of 2001 because of financial reasons. There is a 1-888 crisis number for after hours and crisis informs Kennebec Valley the next day if a client has contacted crisis after hours. Until last November, CSWs had beepers for after hours services. Because of finances and the fact that the CSWs were not being used, that procedure ended.

Kennebec Valley previously had a contract to provide crisis services with Crisis and Counseling. Kennebec Valley continues to receive complaints regarding crisis services although not as many as were received during the year prior to Ms. Pellegrini's 11/02 testimony. Clients felt that they were not being heard and understood by the crisis worker. Ms. Pellegrini stated that there has been a major change in crisis services since the new director took over, which was in December, 2001 or January, 2002. Prior to the new director's arrival, there were access problems in the crisis unit.

Clients can go anywhere in Maine on a voluntary basis for crisis help. On an involuntary basis, the clients have to go to the units that take involuntary admissions, including AMHI, Acadia, and Spring Harbor. She did not know whether the pattern for hospitals would be different for class members.

Ms. LaPointe testified that, during the night, her clients call crisis services on their own. Crisis has agreed to call the case manager the next day if the client uses the services. There are no case managers on call after hours. During the day, the clients call their case managers. The case managers do not do an assessment for crisis; clients are referred to Kennebec/Somerset crisis center.

In 2002, Mr. Rodman retained an expert consultant, Technical Assistance Corporation (TAC), to assess the crisis services in Maine. The system-wide directive was to avoid hospitalization as the remedy for crises.

***105** Evette Jackson works for TAC, which is a private not-for-profit technical organization that provides assistance and consultation to public and private agencies in the areas of mental health and substance abuse services. She has worked for TAC for three years. She has extensive experience working on site with the agencies with regard to the special needs and requirements of an agency. TAC develops strategic plans and does program reviews to look for efficiencies and effectiveness of mental health programs. Based on very lengthy testimony about her qualifications, the court concluded that she was qualified and, in fact, was an excellent witness.

Ms. Jackson was project manager for the team. They did not compare the Maine crisis program to programs in other states. The Court Master requested an evaluation of how well Maine's system functions within Maine's own standards or goals. There can be very different systems in other places. A comparison of other states would complicate the process and raise more questions than would be answered. She conducted two reviews in April and August, 2002. In April, the team interviewed clients and key personnel at the facilities. In August, the team conducted interviews and chart reviews. The team wanted to evaluate how the system operated with regard to the provisions of the Consent Decree.

In April 2002, the team members reviewed pertinent documents, interviewed on site, reviewed client records, and visited facilities such as the CSUs. TAC told the Court Master the functions for which it needed information. TAC received a list of point persons and then

provided the list of positions the team wanted to interview. *See* Pls.' Ex. 83. The programs identified the actual people who were interviewed. The programs were selected by the Court Master and represented each Region in the state and rural and metropolitan areas. TAC also provided the list of information and data it wanted to review to the Court Master and to the programs. Documents were provided as a response to that request. *See* Pls.' Ex. 84.

In April, 2002, the team spent a day in each program. The team requested fifteen class member charts, which was approximately 15% of the population at a site. The program selected the records based on the criteria provided by TAC, which included class members with multiple contacts with crisis services within the last six months; class members whose contact with the crisis system resulted in a crisis bed, in home services, inpatient hospitalization, or referral to CSW; class members diagnosed with mental illness and substance abuse; and charts involving different crisis workers. These criteria gave the team a good "snapshot" of consumers served.

The team also conducted consumer forums. Ms. Jackson asked those who attended whether they had used crisis services during the past year. Some people identified themselves as class members. Consumers were confused about who provided crisis services but none of her findings was based solely on information from consumer forums.

***106** The team interviewed clients and added information from chart reviews, which sometimes were helpful. The team attempted to talk to the crisis workers identified in the charts but that was not helpful. In one case, the crisis worker could not remember anything about the case.

In the spring, 2002, Michael Hartman, Cheryl Bellman, and Ms. Jackson conducted three reviews: Together Place, which is operated by Community Health Counseling Services (CHCS); Amistad, without requested information, and 100 Pine Street in Lewiston, which is operated by Tri-County. They spent an entire day at each site. In August, 2002, the methodology was the same and the team spent two days at Ingraham. At the Court Master's request, the Ingraham review involved a random selection of 24 charts of class members served. The other sites had fewer class members than Ingraham. After the review, there was some follow-up between Ms. Jackson and some of the programs.

After the April review, her concerns regarding crisis services were the following:

(1) underutilization of crisis residential units in many programs and the resulting effect on providing the least restrictive option to delivering services in the community and access to hospital beds. This problem was evident from the documents reviewed and from the interviews. Underutilization is defined at 70% occupancy or less. CSUs are an expensive resource not to use. Further, in-patient admissions could be diverted to CSUs because the capacity is present in Maine. In response to the defendants' counsel's questions, Ms. Jackson stated that an 86% figure for resolving crises with no hospitalization was meaningless without more information, such as whether the person went to a shelter or returned to the emergency room. Similarly, a 16%-20% hospitalization rate requires context. Communities have developed a percentage that is acceptable; Ms. Jackson suggested that Maine is one community that might want to do that.

(2) underutilization of in-home crisis supports. In-home crisis support services are provided by crisis intervention services as compared to in-home community support services, which are provided by agencies the Department contracts with other than crisis agencies. In-home crisis supports are more intensive and require a hired credentialed staff. In-home community supports serve client needs to maintain the functioning of the client in that setting and are time-limited. In-home crisis support services can be open ended in order to resolve the crisis.

(3) frustration experienced in accessing in-patient hospital beds, particularly the wait time, the length of stay, and voluntary versus involuntary admissions. With regard to wait time, 16% of consumers wait more than four hours, based on the Initiative Group data, and 84% of consumers wait less than four hours. Ms. Jackson concluded that the system was not meeting the consumers' needs because the consumers and program staff say that that the wait time is unacceptable; once the decision was made regarding hospitalization, whether involuntary or voluntary, four hours is a lengthy wait. Given the unique and specific needs of people with mental illness, their condition deteriorates and the emergency room does not lend itself to the needs of this population. This opinion is shared by consumers.

***107** With regard to voluntary versus involuntary admissions, there was a practice of transferring a voluntary admission to involuntary in order to access beds, an "ease of hospitalization." The issue is not number of beds for involuntary patients. The patient charts and staff interviews revealed that a phrase, "procedural blue papers" has been coined to describe a process of turning a voluntary admission to an involuntary admission. One crisis support worker had done two such procedural blue papers in the week before the worker was interviewed. After evaluation, the worker decided that the patient needed a hospitalization. The patient agreed to hospitalization but hospital staff requested that the patient be admitted on an involuntary basis. This issue was also raised at the consumer forums.

(4) the "mounds and mounds" of data generated to look at

the system. Ms. Jackson described the same deficiency regarding the system's inability to determine progress or compliance that others described. Goals have not been set by the Department in specific areas to allow programs to measure themselves to determine whether the programs are achieving the Consent Decree requirements. In spite of "all this wonderful data," as she described it, there is no process to determine whether a goal is achieved because there is no standard against which the data can be measured. As the system now stands, the impact of any changes is unknown. There were no goals or measurements for any program Ms. Jackson reviewed. At the end of the interviews with providers, the team conducted a debriefing and raised the issue of goals and targets. The providers offered no goals or measurements when that issue was discussed. Although performance indicators exist, crises do not operate in vacuums. The goal must be established by the CSW and the in-patient staff to ensure the goals are reasonable and that everyone is "on board."

In her work in the District of Columbia, for example, Ms. Jackson and others formulated targets and redefined the operation to meet the targets, which included the number of admissions and length of stay. National standards focus on elements for crisis programs. Maine has the elements of best practices, including, for example, CSUs and the 24-hour telephone line. Absent national standards, the system must set goals and measurements in collaboration with crisis programs in terms of what is viewed as appropriate and fair. Those may vary from community to community and it is the responsibility of the community to come up with its own goals and measures.

The 8/02 review of Ingraham revealed the same concerns as the April review. In addition, an issue arose regarding the continuity of care. The crisis workers at Ingraham and the CSWs in the Portland agencies had little follow-up after the consumer had contact with Ingraham. A second concern involved coordination and communication with the hospitals.

Ms. Jackson concluded from her work that the agencies she reviewed were in compliance with paragraphs 99(a), 99(b), 99(c), except for Rumford, 99(d), except for Rumford, although the CSUs are underutilized. Compliance with paragraph 99(e) was very difficult to determine absent a starting point and goal. A review of the charts, however, showed that there is no capacity to follow up and make multiple contacts with the client while in the hospital to see if an alternative might be appropriate. There is no qualifier in paragraph 99(e); multiple contact and follow-up are required always. Because the crisis workers are juggling cases, they have no capacity to maintain contact with the clients. On some units, the staff has dual roles. They are covering the phone lines and the mobile crisis unit and cannot do both at the same time; this decreases the availability of the mobile crisis units if the staff has to answer the phone. Follow-up is episodic and rare. Further, although release is a client choice, the team was unable to determine whether release was client choice or an administrative issue. Contrary to the defendants' suggestion, the reduction in the AMHI census does not alone show compliance with paragraph 99 because paragraph 99 does not apply only to AMHI.

***108** Based on the concerns and findings of the April and August reviews, including access of in-patient beds, utilization of community residential units, use of in-home crisis services, and placement of a consumer based on need as opposed to what is available, she concluded that the Department is not in compliance with paragraph 100.

In order to be able to make determinations whether crisis services are meeting client needs, Ms. Jackson recommended frequent discussion with consumers and a sincere effort to act on their concerns. Concrete goals in areas of concern to consumers must be established and priorities set. Progress must be monitored by a comparison of the targets and the client charts to determine if the needs are being met. This has to be a flexible process of goals and targets. External review also is helpful in providing feedback and perspective concerning reasonable goals and targets.

Michael Hartman was contacted by Evette Jackson for help on the file review in Maine. *See* Pls.' Ex. 87. He is employed by the Vermont Department of Mental Health.

He reviewed charts to evaluate links between crisis services and case management services. He used Locust, which is a clinical review tool to review objectively the outcome for a person in terms of the services the person qualifies for.

In the April, 2002 review, the team looked at what the case manager said, related that to what the crisis people said, and followed through. The charts reviewed represented a wide range of Axis I disorders and approximately 20% to 40% of Axis II disorders. They reviewed charts of people receiving a broad base of services, including class members and people who had recently received crisis services.

The team found substantial communication issues between crisis workers and emergency room staff and the staff at receiving facilities. Services appeared in the plans but nothing was linked together. To be effective, crisis must to be linked to services before and after a crisis. The second issue found by the team involved involuntary treatment decisions. There was a good effort to set up crisis stabilization units but the units are not well used.

The team found a huge difference regarding availability of in-home crisis supports, depending on the area. For CSI, 5% or 6% of the contracts had in-home supports;

Rumford had 2% and Bangor had 2%.

The team also found variability in the system regarding what a crisis team is and what a crisis team provides. Not all use in-home crisis supports. In-home crisis supports are a vague concept and are not an integral part of crisis services and, in some areas, there is what Mr. Hartman described as "chaos" about what inhome crisis services are. In-home crisis work can be done by the case worker. Either follow-up should be deployed by the crisis service clinician or the person should be sent back to the case worker for follow-through. The most startling concern was at Ingraham, which had seventy crisis plans for 1,000 people. CSI was more organized. Tri-County had the most confusion about services.

***109** Crisis plans that were developed by one agency but not referenced in another agency's records would not be helpful because the workers would not know the plan existed. The crisis plans did not appear to be the product of the client's involvement in preparation of the plan. This conclusion is supported by testimony from the class members. There is a difference between what the client wants to have happen and what the providers will do.

There is no formal protocol for workers to communicate regarding follow-up. For example, Ingraham and SRS clients had many, many dealings with crisis workers and the case managers did not know about those contacts. The case managers reported that they used to meet with crisis workers to discuss these issues but no longer meet. The team also found the phenomenon of the "missing consumer." An assessment is done and the patient is sent to the hospital. The workers never hear the disposition but within hours they learn from crisis workers that the person is back on the street. This is a communication and linkage problem. Regardless of confidentiality concerns and releases, information that a person was seen and was not admitted can be supplied to a referring agency.

Mr. Hartman handles blue papers in Vermont and understands what it is like to be with someone who says he is going to kill someone or who has no understanding of reality. What struck Mr. Hartman was the low level of concern for the implications of an involuntary admission. The concept of "procedural blue papers" surfaced in every program and was a situation encountered fairly regularly. A worker at CHCS used the term "procedural blue papers" to describe a method to gain admissions to hospitals. Other people, including a person at CSI and the Medical Director at the emergency room at the Rumford hospital, also used that term. Workers felt they had to do blue papers in order to obtain hospitalization. Many clinicians were distressed that they had to write blue papers to meet the needs of receiving hospitals. Even if a consumer is willing to go to the hospital voluntarily, the receiving hospital, usually through the nurse, informs the worker that the hospital will take the patient but the patient has to be blue papered. For example, he saw documentation of a person who went to the hospital and stated that she needed help. She arrived at 9:00 a.m. By 2:00 p.m., she was still there and understandably became agitated. The receiving hospital required blue papers for her admission.

In contrast, in Vermont, people preparing blue papers are required to sign an affidavit with clear reasons why a person requires involuntary hospitalization. He was aware that in Maine, a crisis worker performs an assessment, a doctor performs an examination, and the papers are presented to a judge.

The ramifications of admission status are significant. On an involuntary admission, the patient no longer makes decisions, is locked in, and seclusion and restraint can be used. An involuntary treatment situation portends the deterioration of the therapeutic relationship. Sometimes more than half of those involved in a crisis were involuntarily admitted, although the variation among the regions is substantial. *See* Pls.' Ex. 88, p. 4/6. That percentage is high. Based on the numbers for involuntary hospitalization, Mr. Hartman concluded that something is amiss in Region II and possibly in Region III. If in-home crisis supports were increased, the number of people involuntarily admitted would decrease and the length of stay in the hospital would be shorter.

***110** Mr. Hartman agreed that resources are important but the way in which the resources are used is just as important as having them. Maine has sufficient hospital beds: one for every 2,200 adults; Vermont has one for every 3,000 adults. Accessing beds is difficult, however, because of difficulty in stepping down people from the hospital and underutilization of the CSUs. Thomas Lynn, who works for CHCS in Bangor, expressed to Mr. Hartman his frustration with regard to the step down program from the hospital. Mr. Lynn was not getting referrals and was concerned that he would not be able to staff his CSU because of the occupancy rate.

A greater ability to absorb people at the community level from the hospital and to deter hospitalization is needed and that requires communication. One facility told Mr. Hartman that it had the ability to take more people from the hospital but the hospital did not recognize that. Some emergency rooms felt that they could not use a CSU because that would be a step down and contrary to federal regulations. There clearly is confusion about this topic.

Vermont has target goals developed by state and community mental health centers. The workers try not to admit on an involuntary basis beyond a certain number of people. If that number is reached, an immediate review of everyone admitted after that time is performed and all of the numbers of admissions are monitored. Vermont workers also try to maintain the CSUs at 80 or 85%

occupancy and steer patients from in-patient settings to the CSUs. The CSUs can meet their costs if they are 75% occupied.

The length of stay in Maine hospitals has huge variability. Some hospitals have a 5.6-day average stay and some have a 12-day average stay. Some hospitals also had a high percentage of people who exceeded the average length of stay. In Vermont, hospitals and CSUs aim for a seven-day stay. After that time period, a determination is made of the clinical rationale for keeping the patients at the hospital or CSU.

Mr. Hartman participated with Ms. Jackson in the debriefings with providers. The staff raised no objections or challenges to the findings made by TAC. The staff acknowledged that the system has significant challenges, especially regarding communication among providers.

Mr. Hartman concluded that some adequate efforts are made to provide crisis services but there is a failure of linkage and a failure to recognize that failure of linkage. *See* Pls.' Ex. 68. Because of unnecessary blue papers, wait time at the hospital, inability of people to step down from the hospital, inability of crisis stabilization beds to be occupied, and the inability to work with people, Mr. Hartman concluded that Maine's crisis system is not meeting the needs of its consumers.

The conclusions of Ms. Jackson and Mr. Hartman show that what is actually happening in the crisis system differs from the procedures testified about. They have established a sufficient basis for their work and their conclusions are supported by the testimony of Dr. Tedrick, the testimony of the class members and their relatives, and the admissions of the defendants' witnesses. The conclusions are given significant weight.

***111** Dr. Phillip Tedrick from Maine General Medical Center's emergency room confirmed the difficulties in Maine's crisis system. He saw delay in dealing with patients in crisis in the emergency room. During 2002, the delay exceeded eight hours on 157 occasions. The medical clearance protocol has reduced delay from the receiving hospitals but has had no effect on case worker availability or bed availability. *See* Pls.' Ex. 68.

On two occasions during the month preceding Dr. Tedrick's testimony, there were no beds available in Maine for needed admissions. When no bed at AMHI was available, Dr. Tedrick generally made someone from the Department, either Dr. Fine or Ms. Stover, aware of that fact. The Department responded that it could not create a bed, if a bed does not exist, it does not exist, and that Maine General was "stuck" with the patient.

Commissioner Duby formed the Initiative Group to establish a dialogue between hospitals and crisis workers because of acknowledged communication problems. There were a series of procedural issues between hospitals and crisis workers, not all of which are resolved, including how to provide more evaluations outside of the emergency rooms. The Commissioner agreed that, as of 1/25/02, not all crisis services were met. There were situations where someone needed a hospital and there was a difference of opinion between the hospital and the psychiatrist regarding what should take place. The Commissioner was unable to name the percentage of class members' crisis intervention needs that were met as of 1/25/02.

Vocational Opportunities and Training

The defendants rely on a stipulation and various reports and procedures as evidence of compliance with the requirements of these paragraphs. *See* Jt. Exs. 1, 24, 34; Defs.' Exs. 1, 63, 64; Pls.' Ex. 89. These services must, however, meet ISP-identified needs. *See* Pls.' Ex. 67, p. 2.

Treatment Options

With regard to treatment options, Claire Harrison stated thatprofessional assessments are done through out-patient services and include everything from diagnosis to treatment. These are funded through grant and MaineCare seed money and sometimes wrap-around funds.

The Department has contracts using grant and seed funding for group and individual psychotherapy. The agencies that receive that funding do this work. The Department does, through grant and MaineCare seed money, contract funding for psychopharmacological therapy. In York County, there is one comprehensive mental health facility for this. In Cumberland County, there are various ways this is done. Occupational therapy is done by grant funding. The Department has contracts with statewide occupational therapy groups and wrap-around funds are used. Residential treatment programs incorporate occupational therapy. Recreational therapy is done with wrap-around funds, contracts with social clubs, and grant funds.

The Department has contracts using both seed and grant funding for substance abuse counseling. The providers are increasingly providing substance abuse counseling so a consumer does not have to go to two places for counseling. There are pilot projects regarding alternative treatment, and funding and training for sexual and physical abuse. The treatment recovery empowerment model is employed.

***112** There are additional options. For example, deaf counselors are available for deaf consumers. There are intensive case management programs. The medical

director provides services to clients. The case managers help to identify services that a consumer wants or would benefit from.

Psychiatric services are provided by CSI in York County; the contract includes grant and seed money. In Cumberland County, some psychiatric services are provided by the Region I Medical Director, Arthur Dingley, who works with some clients on a short-term basis and some on a long-term basis. He bills under Medicaid. There are contracts with Spurwink for psychiatric services. There are also contracts with SRS and Shalom. Psychiatric services at Shalom and SRS are bundled with community support services. If an individual without Medicaid is in Cumberland County, he would go to Portland Help, which has two psychiatrists and which is funded by grant money, Medicare, or private insurance. Psychiatric services at CSI and SRS are available even if a person has no insurance and Medicaid. Community support services are available without Medicaid if the person is eligible, although he may be placed on a waiting list.

Anne Jennings has been the Director of the Office of Trauma Services for the Department for seven years. In 1997 or 1998, her staff numbered four, including 1 Department person and 2 consultants. She now has 1 part-time secretary and she has been at that level of staffing for slightly less than one year. She participates in meetings with the National Association of State Mental Health Program Directors (NASMHPD) regarding trauma and is involved with the Substance Abuse Management Services Association (SAMSA). She does not participate in the QI review team.

A history of trauma means that an individual experienced in childhood sexual or physical abuse, severe neglect, or witnessed violence or anything that was a shock to his system and that results in serious mental illness, substance abuse, re-victimization, homelessness, and other adult difficulties. A trauma-informed system provides training, interviews, assessments, and administrative support with consumer involvement. All elements come together to create a system in which trauma specific services can be sustainable. The Department's policy regarding seclusion and restraint is informed by a history of trauma. *See* Defs.' Ex. 54 (7/11/02).

She was involved in the trauma plan in the 5/96 plan and she was involved in amendments to the original plan. The overall objective was to develop a trauma-informed service system in order to respond to people with a history of trauma so that these people feel welcome in the system. *See* Jt. Ex. 1 (the Department's 8/01 plan amendment, pp. 65691-65718, approved by the Court Master). The implementation phase of this plan to create trauma-based options, services, supports, and resources is December, 2001 through June, 2002. *See id.* at p. 65713.

***113** The 8/01 revisions to the plan involved going "back to the drawing board." The Department had intended to have safe houses for each region. The Region III safe house operated seven to nine months and the Region II safe house operated two to three months. These places proved to be clinically harmful to some people and there were problems from the beginning, including a suicide It took the Department six to eight months to determine that these places were not working.

The Department did an assessment of class members and found that 74% have a history of trauma. No such assessment was performed for all of the Department's clients.

A pilot project is underway at the Rumford Tri-County unit. As of 1/25/02, the Rumford model plan was made, the focus groups had been held, a manual had been distributed, and a consumer advisory board had been implemented. In May, 2003, the Rumford group will present to the larger Tri-County organization to see if the plan will be implemented on a larger scale. The plan is to consider the outcome of this pilot project and to interest other organizations in Maine, including CSI and Sweetser. In addition to this model project, the Department has a plan to develop an ACT Team for treatment of trauma survivors in RegionI.

The Trauma Service Implementation Team includes all mental health team leaders from each region. Brenda Harvey from the Office of Program Development, a representative of the Office of Community Service Development, people from the Tri-County pilot project, representatives from the Maine Coalition Against Sexual Assault, a representative from AWAP, and a representative from the Office of Substance Abuse attend the meetings. There are no members of this committee who are treatment survivors and receive these services. The team meets bi-monthly and receives reports from the Tri-County pilot project. The team was formed to ensure that the 8/01 revised plan is carried out.

The system is designed to respond effectively to people with a trauma history, to provide policies and procedures that are helpful and support the provision of services to people, and to bring to Maine things that are effective in this field. The plan to achieve a trauma-informed system includes raising awareness and public education, training and educating professionals, developing policies and procedures, and providing services and support. *See* Jt. Ex. 1 (amendments), pp. 65703-65707; *see, e.g.,* Defs.' Ex. 58, pp 2, 5-8. The plan clearly is in the beginning phase only. *See, e.g.,* Jt. Ex. 22, p. 73716.

The Department has only partial data regarding trauma-informed and trauma-based treatment options, services, supports, and resources. *See* Jt. Ex. 1, p. 65715.

The integrated trauma treatment team is not yet implemented and is on hold while Region I considers the pilot program. There is no data attached to the quarterly reports yet with regard to this program. Ms. Jennings had no data regarding trauma-informed inpatient service within AMHI and no data had been included in any quarterly report. *See* Jt. Ex. 1, p. 65716. She had no data with regard to intensive residential treatment and support. *See id.*

***114** An annual training conference is scheduled for spring, 2003. The previous focus was on mental health; this conference will focus on substance abuse. The conference is designed to bring best practices to Maine. The conference is targeted primarily for clinicians but consumers and survivors are invited.

The Department has funded a phone for the Maine Coalition Against Sexual Assaults for four or five years. The Coalition is also committed to offering support groups and empowerment groups. The Department provides consultation for clinicians who work with people with trauma disorders or provides an expert to do an evaluation. Services are accessed through the mental health team leaders. A Safer Place has been set up for people abused at Baxter.

She considers Listserve, the consumer newsletter, phone calls, people she meets and talks to, other documents, and an updated mailing list as indicators for effectiveness and accountability. They are collecting performance indicator data for the quarterly reports. She has not made any recommendations to supervisors about including performance indicators about trauma sensitivity.

Ms. Jennings was consulted by the Department regarding the status of implementation of the trauma plan as of 1/25/02. She responded that they had moved forward and had implemented some services. She had questions regarding the integrated trauma team, which is not yet in place. She understood it would be in place after 1/25/02 and then she understood it would be on hold until the program was assessed. When asked at trial whether she told the Commissioner that they were in substantial compliance regarding this plan and the model project, she replied that she did not remember what she told the Commissioner at that time. She admitted that, in retrospect, they were not in substantial compliance on 1/25/02.

The testimony from class members and their relatives regarding inaccessible or unavailable services, along with the testimony of Ms. Jennings, confirm noncompliance with these paragraphs.

Recreational/Social/Avocational

The defendants rely on the existence of contracts and the Advocacy Initiative Network as evidence of substantial compliance with these requirements. *See* Jt. Ex. 33; Defs.' Exs. 101-109; *see also* Jt. Ex. 1, pp. 65-69; Defs.' Ex. 110. That evidence does not show that the programs have allowed class members to utilize, improve, or gain recognition for their avocational talents. *See also* Jt. Ex. 1, pp. 65-66.

Transportation

With regard to transportation, there are specific contracts for transportation for York and Cumberland Counties. Wrap-around funds are used for taxis, buses, airline tickets, and car-related expenses. *See also* Defs.' Ex. 56A.

The testimony from class members and defendants' witnesses made clear that transportation remains a significant barrier to accessibility of ISP-identified services to class members.

Family Support

***115** Carol Carothers has been the Executive Director of NAMI -Maine for four years. She is responsible for family and consumer reports; information; training; the warm line, which is available 8 a.m. to 5 p.m., Monday through Friday; and respite services. The State funds NAMI's services. *See* Jt. Ex. 32; Defs.' Ex. 87.

She provides reports to the Department. *See* Defs.' Ex. 63 (Tab "Family Support," p. 5). In one contract, the Department required reports regarding compliance with the Consent Decree and she provided the reports. NAMI also conducted surveys, although the Department gave no instruction on how to do the surveys.

NAMI's contracts require compliance with paragraphs 109 through 111 of the Consent Decree. She assessed how to educate people about the terms of the Consent Decree. Eleven of twenty-three affiliate leaders responded to a survey sent out by NAMI, 73% received education regarding the Consent Decree; 75% of that 73% received the information from NAMI. *See id.,* p. 4. None reported receiving information from the Department or mental health providers. Ten of twenty-six mental health providers responded to a NAMI survey regarding Consent Decree training.

NAMI provides information on the number of people it trains. *See id.,* pp. 8-10. The Department did not help NAMI design the survey. The results are not particularly significant because of the low response rate. The recommendations in the report are those of Ms. Carothers. *See id.,* p. 11. She included recommendations in prior fiscal years but received no response and was asked by

the Department not to include recommendations in the future.

For fiscal year 2002, NAMI changed its methodology. It reports on services provided, the number of calls, and what the consumers and the families say regarding services. NAMI did not report on whether mental health agencies are making referrals of family members to support groups.

NAMI provides over the phone information regarding the Consent Decree and patients' rights, information regarding mental health services in Maine, direct support to family groups, education on treatment and how to care for persons with mental illness, and respite services. That effort does not constitute the developing, and supporting family support services. NAMI does not provide information on group counseling or psychoeducational programs.

The Department concluded in its Family Support Services QI Report dated 7/01 that "[i]t appears that mental health providers do refer families to area family support groups." The support for that conclusion was the NAMI-Maine report, "The Adequacy of Family Support Services for Families and Individuals Coping with Mental Illness in Maine: 2001 Status Report," which the Department incorporated into the QI report without discussion. The NAMI report provides:

> Mental health providers do not maintain relationships with family support groups, and do not have complete knowledge of existing resources. It is therefore likely that a majority of families do not know where to get help and are not informed by their local mental health providers. This conclusion is confirmed by the NAMI-Maine database of calls, which clearly shows that families and consumers often do not know what help is available or where to get help.
>
> ***116** Mental health providers do not appear to be following Consent Decree guidelines in assisting families to find needed support. In responding to the survey about the process of linking families to support services, only three mental health provider organizations indicated attempts to actively assist families with finding those services.

See Defs.' Ex. 63. Inexplicably, the defendants cite this report as evidence of compliance with paragraph 110. *See* Defs.' Evidence Grid, ¶ 110. In October, 2001, the Department concluded that it could provide assistance to NAMI.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 85-87, 88-92, 93-96, 97-98, 99-100, 101-102, 103-104, 105-106, 107-108, 109-111 of the Consent Decree.

VIII. STANDARDS FOR COMMUNITY PROGRAMS: Paragraphs 112-132

Elizabeth Harper is the Director of Licensing for the Department. She supervises the licensing unit which consists of three positions and an administrative assistant. This unit licenses all mental health agencies, substance abuse agencies, the EAP system, and methadone clinics and provides technical assistance to agencies to obtain licenses and for plans of correction. Technical assistance to agencies also includes policies and procedures, help with documented evidence, a description of how the process works, and ADA. The unit does some training but that is not their principle goal now.

Ms. Harper described her procedures. Licenses offered include the following: a provisional license, for up to one year for a new agency; a license for up to two years for an agency that has been in operation for a long time and has a good compliance record; and a conditional license for one year if an agency has issues that must be addressed. Five or six facilities now have a provisional licensing status. The licensing unit calls these facilities to make sure that they are doing things in a timely fashion. The licensing unit tries to visit these facilities three to six months before the license due date so problems can be corrected. Facilities with provisional licenses call licensing with questions and if they want training.

There are also a few adult mental health facilities that have conditional licenses. Licensing has more contact with these facilities and requests a plan of correction. Sometimes the conditional licenses will be for only three months, in which case progress is expected to occur much more quickly than with a conditional license for a longer period of time. If the deficiencies will take longer to address, the period for the conditional license is longer. If there are significant problems, a one year conditional license will be issued. A conditional license can be issued if there are multiple problems or if licensing believes that the facility does not have the appropriate employees.

Joint exhibit 5 includes the licensing standards. *See* Jt. Ex. 5; *see also* Defs.' Ex. 86. Page VI includes the regulations promulgated pursuant to the authorities cited. *See* ¶¶ 130-131. All agencies with mental health licenses are expected to meet core standards. *See* Jt. Ex. 5, pp. 1-32. Specific requirements, depending on the service, are also listed. *See* Jt. Ex. 5, p. 33 *et seq*. All of the standards are expected to be met for each service an agency provides. Joint Exhibit 6 is the licensing packet for mental health, which is sent to new agencies. These include the RRMHS. *See* Jt. Ex. 8.

***117** Ms. Harper explains the process, the application, and fees to agencies that want a license or want to add a

service. *See* Jt. Ex. 6, pp. 71203-208 (application); p. 71209 (review checklist for information needed); p. 71210 (list of things to consider); pp. 71236-71257 (checklist to see if in compliance); p.-71259 (what is in client record); p. 71263 (staff interview form); p. 71264 (client interview form). Licensing performs random interviews, in which only the clinical staff are interviewed. During every licensing review, staff and clients are interviewed. The number of interviews depends on the agency. Sometimes licensing allows the agency itself to choose who will be interviewed. If the agency provides only one service, licensing may do only one interview.

After the agency receives a license, licensing makes repeat visits. Deficiencies are documented and the agency is asked for a plan of correction within a particular time frame. If the problems are serious, licensing returns to the agency to determine whether the problems are remedied. *See* Defs.' Ex. 64, Training, p. 5 and 3/14/01 Attachment.

A full licensing review is scheduled every two years. The review can take two days to three weeks, depending on the agency and the size of the agency. *See* Jt. Ex. 7 (licensing reviews from 1/01 to 10/02).

After testimony about the expected procedure for licensing, Ms. Harper discussed what was actually happening with licensing. She admitted that when she began her job in January, 2001, the reviews for some agencies were five years overdue. One overdue review was for Bancroft Neurohealth, discussed above, which eventually lost its licensing. Complaints included misuse of client funds, RRMHS violations, issues with quality of treatment, and issues with safety and quality of care. At least several months elapsed before these issues were addressed.

The LSWs who work in the licensing division receive on-the-job training because most do not begin with a licensing background. At the time of her testimony, Ms. Harper had lost her third licenser and was doing many more reviews herself. She had been told the position could be filled and the unit hoped to hire that person by the end of 2002.

Licensing was in arrears in performing reviews as of July, 2001. *See* Defs.' Ex. 63, 3/14/01 Attachment to Training. No further information on this issue was provided in December, 2001. *See* Defs.' Ex. 64 (one page Training summary). As of 12/31/01, there was a backlog of review for 30 agencies. At that time, the Department expected to be current by June, 2002. As of the date of Ms. Harper's testimony, the Department was still in arrears on reviews.

The defendants reported in the December, 2001 compliance report that there were violations regarding paragraphs 113, 116, and 117. *See* Pls.' Ex. 89, p. 43. No further explanation was provided other than "the deficiency could be small or large." *See id.* These deficiencies were not explained by Ms. Harper.

***118** No data are collected regarding training on the perspectives and values of consumers of mental health services by consumers. *See* Defs.' Ex. 63, Training, p. 7. Anecdotes do not satisfy the requirements of paragraph 280. ¶ 121.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 113-114, 116-117, and 118-129 of the Consent Decree.

IX. STANDARDS GOVERNING THE AUGUSTA MENTAL HEALTH INSTITUTE: Paragraphs 134-223

Lisa Kavanaugh testified that there were things she wanted to know when she took the job at AMHI, including whether the staff was adequate, the requirements of the Consent Decree, what requirements had not been fulfilled, and understanding of how the hospital operated. She agreed that one area that needed improvement was information management.

AMHI is a 103-bed psychiatric hospital licensed by the DHS, certified by the CMS, and accredited by the JCAHO as of 1/25/02. *See* Defs.' Ex. 3; Jt. Exs. 14, 15. DHS licensing determines AMHI's ability to operate as a specialty hospital in Maine. There are 140 standards that impact AMHI. The CMS certification is required in order for AMHI to participate in Medicaid and Medicare funding.

AMHI cares for the most seriously ill people in Maine, including people with very high acuity and people who cannot be cared for safely by a community hospital because of acuity, chronicity, or potential for violence. AMHI has forensic patients and civil commitment patients. There are, on average, approximately 50 civil patients at AMHI on any day.

The senior leaders of the hospital comprise the AEC, which meets at least weekly. AMHI has a governing body required by CMS, JCAHO, and the DHS. This board monitors the hospital's functioning.

In early January, 2002, AMHI became affiliated with Dartmouth Medical School. The contract specifies that Dartmouth provides psychiatric services to AMHI, including Medical Director Nelson, staff doctors, and a fourth year resident. During the winter, 2000, the 119th Legislature approved $33,000,000.00 for the construction of the Riverview Psychiatric Center to, essentially, replace AMHI. Construction began in March, 2002. The project was on time and on budget at the time of her testimony. Ms. Kavanaugh stated that the new Riverview

facility occupies her time and planning.

The forensic unit has 27 beds for male forensic patients and there are more forensic patients than that number on any given day. An average would be 30-32 males and four to six females. The Consent Decree provides for no more than 70 civil patients. The average census of nonforensic patients is 90 minus 30 or 35. AMHI is licensed for 103 beds but Superintendent Kavanaugh was not comfortable putting patients in all of the beds because of the acuity and diagnoses of the patients, their gender, and the building itself. She did not like to exceed a census of 90 patients. If the patients had low acuity, AMHI could have 95 patients but she will not go beyond that number.

***119** The term "capability" means physical beds and staffing to meet the patient's care needs. The term "capacity" means number of beds. *See* Pls.' Ex. 6. In January, 2002, 36 people were not admitted to AMHI due to a lack of capability. *See* Pls.' Ex. 6, p. 2. AMHI does not track what happens to those who are not admitted because of lack of capability. As of July, 2002, 62 patients were not admitted due to a lack of capability; 22 patients were not admitted due to a lack of capacity. Superintendent Kavanaugh agreed that that caused her some concern. After many, many questions from plaintiffs' counsel, she finally agreed that the patients on this list were not admitted at AMHI because of a lack of capability or a lack of capacity and not for other reasons, such as a referral of the patient to a psychiatric unit first. When asked whether these numbers of people not being admitted indicated a problem with the health care delivery system, she testified, once again, that she would not characterize that as a problem. This has been discussed at initiatives meetings but they had not looked at these specific numbers.

She had requested and received funding for two additional psychiatrists and some mid-level practitioners and staff at Preble Street and the Capital Community Clinic to address unmet needs in the community. The Preble Street position had been offered but was not accepted. The Capital Community Clinic position had been hired but was going through the credentialing process. Through these positions, she hopes to help keep people in the community and to discharge patients in a timely fashion. She hopes to address timely discharges and the waiting time for appointments for community services.

Dr. William Nelson was called as a witness for the defendants. He is a medical doctor, a professor of psychiatry, and is employed by Dartmouth College, Dartmouth Medical School. Through a contract, he became the Medical Director at AMHI on June 17, 2002. His charge from Dartmouth is to prepare AMHI to be a teaching hospital. The goal is to make AMHI a psychiatric center of excellence with regard to patient care, teaching, and research. He did not mention compliance with any specific aspect of the Consent Decree as part of his charge.

The court has carefully reviewed its notes and the 190-page transcript of Dr. Nelson's testimony. Although defense counsel was careful to specify the paragraphs of the Consent Decree that Dr. Nelson addressed, Dr. Nelson did not address the time period prior to 1/25/02. In their post-hearing memorandum and evidence grid, the defendants rely on Dr. Nelson's testimony to show that AMHI is in substantial compliance in spite of the parties' agreement that testimony about post-1/25/02 events is relevant only to any remedy the court may consider.

Benjamin Grasso is a board certified psychiatrist and was at the time of his testimony the Medical Director of Outpatient Services and Director of Clinical Care at St. Mary's Hospital. He also worked at the Institute of Patient Advocacy, which is research oriented and he was starting a part-time private practice. He planned to leave St. Mary's in May, 2003 for private practice and work at the Institute.

***120** Previously, he worked at JBI for two and one-half years and Mercy Hospital in psychiatry for five years. He was the part-time Medical Director of AMHI beginning in the fall, 1999. He was the full-time Medical Director at AMHI from 1/7/00 until April, 2002.

Dr. Grasso was called as a witness by the plaintiffs. As noted, the defendants called as a witness the current Medical Director, Dr. Michael Nelson, who began work at AMHI in June, 2002. Dr. Grasso met Dr. Nelson very briefly once; they never discussed the Medical Director job. Dr. Grasso offered to meet with Dr. Nelson to assist Dr. Nelson's transition to a job Dr. Grasso described as quite complex; the meeting never occurred. Since he left AMHI, Dr. Grasso has received no contact from the QI consultants.

Clearly, the relationship between Dr. Grasso and the AMHI leadership had deteriorated by the end of 2001. Although the complete cause for that deterioration cannot be known by the court, some reasonable inferences have been drawn. AMHI was not prepared, during the final months of 2001 and the beginning months of 2002, to admit or address its very significant medication errors, its admissions and discharge failures, its serious staffing problems, and its inability to treat its forensic patients appropriately; Dr. Grasso was. Because his testimony is supported by other credible evidence and because his description of events at AMHI was not challenged by anything other than evidence concerning procedure and theory, the court accepts Dr. Grasso's very distressing testimony about AMHI's operations prior to 1/25/02.

Dr. Grasso elected to leave AMHI for various reasons, including fundamental differences of philosophy

regarding practice and management between him and the Superintendent, the Associate Commissioner, and the Commissioner. His philosophy included a forthright approach to all matters, including those that AMHI was not performing well. In his experience, information about areas of concern, such as quality of care and safety, were not well received by the AMHI leadership and by the Department. Perhaps the most conspicuous and poignant example was the medication error study conducted at AMHI over a period of time. *See* Pls.' Ex. 10. He sought input and interest from the clinic and hospital leadership to complete the study. He expected that concerns from the study's findings would have been expressed and embraced by all, even if the people involved differed on the degree of concern, and that the study would have been a priority issue, particularly considering the number of errors found. The JCAHO manual, on which the defendants rely, supports Dr. Grasso's expectations. *See* Defs.' Ex. 6, Leadership, LD-33 ("The hospital's principal goal is to help everyone improve work processes without shirking the responsibility to address serious problems involving deficits in knowledge or skill ."). His expectations were not, however, shared by others.

In his job as Medical Director of AMHI, Dr. Grasso supervised the medical staff and was responsible for the quality care providers, the hospital-wide performance improvement activities, and oversight of the admissions policies. He was also responsible for the crisis system and the content and leadership of committees. He met with the Medical Director of BMHI, the Commissioner, and sometimes the Associate Commissioner, on a monthly basis. He was expected to work closely with the Superintendent at AMHI.

***121** Although his initial responsibility was to review all admission referrals to AMHI during normal working hours, he determined early on in his job that it was very important for him to review all admissions. He reviewed 80% to 90% of all referrals. The typical reason for denial of admission to AMHI was that the hospital lacked capacity, no free bed, or the hospital lacked capability because of insufficient staff to accommodate another patient. During his employment at AMHI, denials of admission occurred on a daily basis; 30% to 40% of referrals for admission to AMHI were denied.

Dr. Grasso conferred with the Superintendent and the Associate Commissioner regarding admissions. He gave priority to emergency room admissions. He was aware when he arrived at AMHI that its public statement was that AMHI never denied an admission. In actuality, that was impossible. He exercised his best clinical judgment and ethical judgment. He determined whether a person was appropriate to be admitted or not and he let the Superintendent deal with the contractual or political issues. As an ethical issue, he determined that an unstable or acutely ill person would be taken from an emergency room before someone would be taken from a place with which the Department contracted. He was never instructed to handle admissions other than the way he did but he felt he was required to make difficult decisions.

During the fall, 2001, AMHI received 100 to 120 referrals per month; patients were turned down for admission on a daily basis. There was no mechanism to follow up with patients who were denied admission. On occasion, he would know what happened to a patient because the patient was referred again if he remained in the emergency room. Occasionally, Jim Champine, Admissions Director, would try to work with other institutions regarding particularly needy patients but that effort was sporadic. In general, Dr. Grasso did not know the final disposition of those patients denied admission. He was concerned that acutely ill patients needed hospitalization and they were not being admitted. He communicated his concerns in the AEC, to the Associate Commissioner, and to Commissioner Duby. He also spoke to the Maine Medical Center emergency room physician, Dr. Phillip Tedrick. This issue was frequently discussed.

The AEC acknowledged that the denial of admission of patients to AMHI was a concern. The Committee hoped that patients denied admission would be accommodated as the SLS facilities became available. The hope was that patients who clinically were not required to remain at AMHI would enter these facilities and beds would be available at AMHI. Dr. Grasso continued to review admissions to the last day he worked at AMHI in April, 2002. He saw no change in the admission pattern.

People with the diagnoses listed in paragraph 143 were admitted to AMHI throughout Dr. Grasso's entire tenure. He often discussed the patients being referred with crisis workers in the emergency room and other settings. He conveyed to the Superintendent, the AEC, the Commissioner, the Associate Commissioner, and Regional Medical Directors his concern that crisis workers were assessing acutely psychiatrically ill people at the peak moment of instability. The workers saw the patient in the emergency room or in the patient's home and were asked to make an assessment and a diagnosis, initiate stabilization, and decide the level of appropriate care. Dr. Grasso analogized the situation to asking a CNA to assess a medically or surgically disabled person.

***122** The absence of a psychiatrist as a back-up to the crisis workers was the fundamental problem. Dr. Grasso worked previously in Alaska and Virginia, which have more comprehensive crisis systems and more psychiatrist involvement. Referrals to AMHI were usually made by doctors and crisis workers. He generally knew if a crisis worker had a doctor's assistance. For example, Maine General required medical clearance and not psychiatric consultation. Based on these circumstances, it was not

surprising that there was no initial stabilization of these patients.

As a result of his communication, the Superintendent, the AEC, the Associate Commissioner, and the Commissioner acknowledged this problem. There was occasional discussion with regional Medical Directors to ensure that a psychiatrist was available for back-up. No other action was taken.

The only use of independent consultants recalled by Dr. Grasso was the use of consultants, psychologists or neuropsychologists to do a complete evaluation to determine if AMHI was correct in its diagnosis of a patient and in its assessment of the ability of the patient to respond to treatment. *See* Jt. Ex. 16, p. 1 (1, 9, 18); p. 2 (3, 4, 7); p. 3 (1, 8, 23); p. 4 (1, 8, 12); p. 5(1). This may have been done ten times during the two and one-half years that he was employed at AMHI. The staff had no standard to determine whether they needed an independent consultant. With regard to the use of consultants to actually recommend treatment, AMHI sometimes used an occupational therapist to assist in a treatment program.

His involvement with QI and QA processes at AMHI was extensive, especially with the medical staff. He was responsible for QI for the medical staff. As a member of the Medical Executive Committee, he dealt with the hospital-wide QI plan. He attended all medical staff meetings and the monthly Medical Executive Committee meeting. He reviewed performance improvement indicators. There were, as part of the QI process, approximately eighteen functional teams and he was involved with those dealing with medical usage. The functional teams were established during the months preceding the JCAHO accreditation survey. The functional teams met frequently, at least monthly. When the survey was completed, the teams met less frequently and there was less compliance with the meetings.

At AMHI, a particular person had primary responsibility to monitor compliance with the terms of the Consent Decree, to report to the AEC, and to work with the Court Master and the Department. Becky Green had this job at the end of Dr. Grasso's employment at AMHI. There was considerable discussions during the AEC meetings that AMHI was not in compliance with the Consent Decree. Dr. Grasso eventually was withdrawn from attending those meetings. His opinion was not solicited when the Department was deciding whether to file its notice of substantial compliance.

The antecedent to the Medication Error Study was the Performance Improvement Project. They used PDAs to increase access to information for staff members regarding medication and patients. This plan was presented to JCAHO in January, 2001. That led to another Performance Improvement Plan to consider medication errors. AMHI had what Dr. Grasso described as extraordinarily low rates of self-reported medical errors. The plan originated in the Pharmacy and Therapeutic Committee in early 2001. The entire medical staff was involved, especially in the genesis and design of the study. The medical staff members and the Director of Pharmacy performed chart reviews and the Director of Nursing provided oversight. There was full data collection in the fall, 2001. The data were categorized by the level of severity of the errors: little clinical significance, moderate clinical significance, and high clinical significance. The largest number of errors occurred in administration of medicine. There were also significant numbers of transcription errors, documentation errors, and medical staff errors.

***123** The two principal collectors of the data and Dr. Grasso presented the study to the AEC. *See* Pls.' Ex. 10. Dr. Grasso prepared a research report for publication after the presentation. The report had been accepted for publication but not yet published at the time of his testimony at trial. The publication was confidential according to his contract and he declined to name the publication but stated that it is a highly respected publication.

Dr. Grasso wanted to use the study in a positive way because there is little information regarding medicine at psychiatric hospitals. This study was an opportunity to better address patient safety and address medical errors. He asked the AEC to take the courageous next step. He tried to be inclusive in addressing the issue with the Pharmacy and Therapeutic Committee, nursing, and the direct care staff and tried to allay concerns and anxiety. In 2/02, the Superintendent formed a committee to respond to the study. Dr. Grasso was not asked to join that committee. There was less communication between Dr. Grasso and the Superintendent at that time.

Two changes regarding medication were begun while Dr. Grasso was at AMHI. First, LPNs and not MHWs would dispense medicine. Although there was an effort to recruit LPNs, they had not been hired when he left in 4/02. Second, automated dispensing machines would be used. Other than these two changes, no follow-up study was done or authorized. Superintendent Kavanaugh confirmed that in the spring, 2002, AMHI purchased units for Acudose, an automated medication dispensing unit. As of 10/2/02, this system was on all units at AMHI.

Dr. Grasso had frequent contact with AMHI units on a daily basis. He was an attending physician on the forensic unit and Stone South Middle. He also filled in for absent physicians, in part so that he would know about all the units.

There was a considerable difference in patient access on

the three sections of the forensic unit and the other units. Because of the risk with forensic patients, there was an elaborate process to determine whether forensic patients were safe to be off the unit. The staffing level had a direct impact on the forensic patients' ability to get off the unit. The staff had to prioritize and to try to be fair, given the staff limitations. Some patients could have activities off the forensic unit and some could not. Insufficient staffing levels and inadequate staffing on the forensic unit were discussed at meetings.

Dr. Grasso was concerned about the frequent use of overtime for mental health workers. Some workers volunteered so they could actually control when they had to work overtime. The MHWs very commonly discussed that they would be called and mandated to work overtime; they said they were exhausted. He directly observed fatigue and, indeed, exhaustion in the hospital and was very concerned about burnout. He observed MHWs being very curt with patients. The workers were visibly fatigued and frequently expressed their fatigue. An exhausted worker will have difficulty managing very difficult situations and patients.

***124** The lack of adequate staff, more than fatigue, affected the ability to meet the needs of the patients, including going to medical appointments off the units and leaving the units for activities. The previous Commissioner had attempted to downsize the hospital and reduced staff considerably. There were efforts to remedy this problem in 2001 with the addition of the Assistant Director of Nursing.

Discharge planning in the forensic unit was very different from that in the rest of AMHI. For an NCR forensic patient, the discharge process required petitioning the court to increase privileges, ultimately resulting in release to the community. The forensic team made its own recommendation to the treating clinician regarding the patient's readiness for community release. The process was more complicated for the female forensic patients because they lived on the civil units; there are no female beds on the forensic unit. The civil treatment team was far less familiar with the release process for these forensic patients. The forensic staff instructed and coached the civil staff. Because the forensic treatment team was not familiar with the female patients, that team was more timid with regard to their release. It took weeks to months to review leveling changes for forensic patients on civil units. *See* Defs.' Ex. 125.

If a person was at AMHI due to NCR status, the expectation was that the patient would remain at AMHI for several years before release. With regard to civil patients, the expectation was that the patient would remain at AMHI for up to one week before discharge. For forensic patients, the discharge planning process and treatment did not include an initial, meaningful discussion of housing. Aftercare was a mute point.

No standard was developed for what had to be done by a forensic patient in order to be discharged. This was a gradual process, especially for NCR patients. Evidence of good judgment, self-restraint, that symptoms were under control if a psychotic illness was present, and that a patient could be trusted to be autonomous without a danger to themselves or others had to be shown; that evidence resulted in a slow increase in the level of autonomy. There were delays in determining whether the forensic patients were ready for a different level and delays in filing institutional reports for forensic patients, which was a source of frustration and fear. The Court Master was very helpful in providing feedback during various reviews and recommending a systematic process.

There were AEC meetings regarding the Consent Decree obligations. Dr. Grasso never had a well-formed opinion regarding whether AMHI was in compliance with the Consent Decree requirements and never had a thorough understanding of the requirements or the dynamics of the Department. He initially struggled with the relevance of some of the Consent Decree requirements.

The Consent Decree itself was the standard used to measure compliance with the provisions of the Consent Decree that applied to AMHI during Dr. Grasso's employment. He was responsible to be aware of the provisions that applied to his area but he never went through the Consent Decree to determine all the elements of the Decree as he did with the JCAHO and state licensing standards.

***125** Periodic chart reviews were done using the Consent Decree standards. Although general data was reviewed to determine the extent to which AMHI was in compliance, no standard to measure data for compliance was given.

He was not given any instruction or guidance on how to decide whether AMHI was in compliance with the Consent Decree. He was never told how to measure compliance with the Consent Decree except with regard to the Superintendent's efforts regarding the three-hour rule. Toward the end of his employment, the three-hour rule became an area of great focus. The Superintendent expressed a 90%-100% compliance rate and was avidly trying to show compliance with that counseling provision. There were efforts at the time he left in the April, 2002 to prepare a grid comparing the Consent Decree and JCAHO requirements.

Andrew Wisch has been the Director of Professional Services at AMHI since June 1999. He has Ph.D. from Boston College in counseling and psychology. He is licensed in psychology in Maine. At AMHI, he has clinical and administrative responsibilities for the psychology department, the chaplain, the social work

department, recreation therapy, therapeutic therapy, and vocational rehabilitation. He supervises the dual diagnosis clinicians. Although there are ongoing discussions regarding staffing and the allocation of resources in the AMHI administration, Dr. Wisch was not previously asked questions about increased staffing levels.

A significant part of Dr. Wisch's testimony relates to events occurring after 1/25/02. For example, he discussed at length the Treatment Mall, which opened at AMHI on 9/26/02, and the services available there pursuant to paragraph 155. He stated that AMHI is developing educational programs. He discussed a CSW tracking form, which has been used at AMHI since 1/02. *See* Defs.' Ex. 29. He stated that the staff includes five full-time psychologists but then noted that on 1/25/02, there were three full-time psychologists. He discussed basic groups as valuable and available on an ongoing basis but then noted that he could not say whether the goal setting group was held on every unit as of 1/25/02. He testified that he supervises directly the psychological staff, including the director of the Treatment Mall.

After a careful review of the court's notes of Dr. Wisch's testimony, it is clear to the court that, in general, he was testifying about the current state of affairs at AMHI as of the time of his testimony, October 31 and November 1, 2002 and not about the events that had occurred prior to 1/25/02.

The court will assume that the testimony about job qualifications, credentials, and certifications pertained to the pre-1/25/02 procedure. The psychological staff is credentialed through human resources. The licenses are one file and three references for professionals are checked. Continuing education requirements are the same for AMHI as for maintaining their psychologists' licenses. Social workers are licensed with the Social Work Board and references and CVs are checked. Recreational therapists are not hired without a CTRS certificate. One member of the staff does not have that certification because he was hired before that requirement, but he is qualified. *See* ¶¶ 205-206.

***126** Recreational therapists provide opportunities for leisure and help to develop and maintain skills for daily living, such as cooking, and take the patients out into the community for fun. Rehabilitative aids support the therapists and provide recreational therapy. They are all licensed CNAs except one and that aid has another degree. The chaplin has a counseling license. The vocational rehabilitation therapists are level one MHWs.

The dual diagnosis clinicians deal with occurring mental illness and substance dependence. They are employed through a contract with Crisis and Counseling and are licensed by the Board of Alcohol and Drug Counselors. Their personnel files are at Crisis and Counseling but available to AMHI. Dr. Wisch verifies that they are properly qualified.

Salary reviews are performed regarding the psychologists. The reviews have been done for social workers but he was not sure of the dates of the reviews. He did not know if the social worker salaries are competitive. AMHI has problems recruiting social workers and the social workers do no receive salary increases except for the usual union contract increases. He had no direct knowledge of recreational therapists' salaries at other institutions but does not have problems recruiting recreational therapists.

He is not involved in the administrative process to obtain an ISP. One month before his testimony, the paperwork process for obtaining an ISP for the file was changed. The absence of an ISP in the file could be explained by the fact that no ISP existed but the assumption was that AMHI had not done its job and had not obtained the ISP.

Group and individual psychological counseling is provided by the psychology staff and by social workers with a proper license. An LCSW license is required. As of the time of his testimony, the dual diagnosis clinicians provided group counseling and intervention. *See* ¶¶ 155, 202. Treatment services were part of the overall schedule. *See* Defs.' Ex. 28 (dated December 30, 2002-January 5, 2002; presumably the date is 12/30/01); ¶ 153.

Dr. Wisch was aware that AMHI did not always meet the requirement that a referral to CSW would be made within 48 hours of identifying the need. He did not know the figures for compliance or non-compliance. This forty-eight hour data for the period from 7/1/01 to 1/1/02 was unavailable except from review of patients' charts, which the defendants considered unduly burdensome when responding to plaintiffs' request for this information. *See* Pls.' Ex. 100. Dr. Wisch discussed this with social workers regarding the need to meet that requirement because it was a Consent Decree requirement. Joint exhibit 24 reflects the protocol for CSW referral in effect 1/4/00. *See* Jt. Ex. 24, p. 69680, ¶ 4. A form is used to track data for CSWs. *See* Defs.' Ex. 29. The reports based on this data were not generated until 2/02. The reports showed that individuals were not getting referrals within the 48-hour Consent Decree requirement. Dr. Wisch revised that protocol with CDC Whittington one month before his testimony. Defs.' Ex. 41, p. 32.

***127** As of 1/25/02, individual counseling hours were tracked manually. The billing code was entered on the tracking sheets by the person who provided service.

Dr. Wisch was responsible for oversight of voluntary patients at AMHI for more than six months. Two psychologists not involved in the patient's care review whether the patient requires hospitalization and whether

he objects to the hospitalization. If hospitalization is required and the patient does not object, the case is referred to an outside psychologist. If that psychologist finds that hospitalization is required and the patient does not object, the patient is reviewed again in six months. If the patient objects to hospitalization, he is discharged or commitment proceedings are initiated.

As of 1/25/02, there were patients who had been at AMHI for more than 150 days and who were safe for discharge. *See* ¶¶ 45-47, amended by order dated 2/7/97; Defs.' Exs. 31; 30 (as of 5/23/02); 98; 99. He was aware that there are patients with schizophrenia who are long-stay patients and who are not responding to treatment. The UM chart review results form contains a separate column for whether a patient "Meets Medical Necessity Criteria." Accordingly, the "Currently Safe or Unsafe to D/C" column data is from the treatment plan review form. *See* Jt. Ex. 16.

Joint exhibit 16 reflects 84 patients who do not meet the medical necessity criteria to remain at AMHI and who are safe for discharge but who have not been discharged. *See* Jt. Ex. 16. The parties stipulated that the list, "Patients to Whom Paragraph 94 Applies," represented by plaintiffs' exhibit 9, was filed in court in 1990 -1991. Patient # 3 residing at Stone South Middle as of 1/23/02 was on the list of patients who could have been discharged in 1990-1991. *See* Pls.' Ex. 9; Jt. Ex. 16.

Ms. Whittington stated that the CDCs have procedures for review of the 150-day patients. *See* Jt. Ex. 25, p. 68042 (dated 5/02). She was not assigned to this task. The previous CDC manual dated 1/4/00 contained no 150-day patient list protocol for review. *See* Jt. Ex. 24.

Dr. Wisch did not participate in the decision to file for substantial compliance as of 1/25/02. The issued was discussed at AEC. The hospital did not conduct a full evaluation of patient records or discharge plans prior to 1/25/02.

James Talbott was a social worker at AMHI from 5/12/00 through 6/6/02; from 12/5/01 through 2/11/02, he was on administrative leave. He was involved in discharge planning, all treatment team meetings, helping patients obtain CSWs, and trying to do therapy with clients, although at AMHI social workers did not generally do therapy.

At the time of his testimony, Mr. Talbott worked at Merrymeeting Behavioral Health Associates, where he did in-home supports for children with special needs and mental illness. He has a Masters in Social Work from the University of Denver. He is a LCSW in Maine. He was the unit social worker at AMHI.

***128** Mr. Talbott received little training when he was hired at AMHI. He was put on the unit and told "here you go, go to work." He received a packet, filled it out, handed it in, and that was called training. He agreed that grand rounds at AMHI provided an opportunity for training. These were sometimes canceled or superseded by another type of meeting, however. He went to professional seminars outside of AMHI on his own initiative for his own professional growth. Training had improved by the spring, 2002.

He was involved in training other staff at AMHI. In 12/00, he trained a newly hired social worker. He was given no instruction on training and simply used his experience on the unit.

Mr. Talbott was the only social worker on Stone North Upper, which is the very acute patient unit. Generally, there were two social workers per unit but three were needed because of the acuity level. In mid-February, 2002, AMHI tried to hire social workers because there were too few social workers on the units.

The normal staffing ratios of social workers to patients should be one to twelve or thirteen. The rate was one to eighteen or more for nine months on Stone South Middle. When he returned from administrative leave in 02/02, a woman left employment at AMHI and was replaced with a part-time worker. This created stress and the inability to give quality service. Mr. Talbott said it was hard to keep everything straight and he was required to prioritize whom he would work with one day and whom he would work with during the next week. He was not able to spend time with patients to get to know them.

Staffing levels were a problem for the entire time he worked at AMHI and affected the patients' ability to get off the units. If there was insufficient staffing, the patients did not go anywhere because of concerns for safety.

He was involved in treatment teams. The level of patient involvement in shaping the plan was minimal. The patients attended the meetings but the plan was either already written or developed without the patient's input in the plan. When he was asked what the role of the patient was at the treatment team meeting, he responded, "that's a good question." With regard to assessment forms, he said he did not think they ever used the universal assessment form or the various assessment forms in developing the treatment plan. *See* Defs.' Ex. 15. He did not recall using information from assessments to design an individual treatment plan.

It was fairly common for patients not to attend treatment team meetings, especially long-term patients. The ICMs participated in the meetings but the CSWs from the community did not attend the meetings at AMHI because it was too far to travel and they were not paid for travel or their time.

He was the chief discharge planner for his unit. He ensured that the patients had a place to go, a CSW or ICM, and appointments scheduled. Sometimes the availability of resources in the community affected the discharge. Access to psychiatric services and housing were was especially difficult.

***129** He had no involvement in QI and QA. They had "lots of meetings." He described QI as meaning improving the quality and he said that he was not involved in it.

B. Environment

Eric Gilliam works for the Department and has been the Director of Support Services at AMHI since May, 1997. He is responsible for maintenance, engineering, safety, and dietary requirements. All of the maintenance at AMHI is automated, which permits tracking for preventive maintenance for all major mechanical systems, including heat, ventilation, and air conditioning. If there is a complaint, a computer will generate a work order and an individual will check the complaint. People in the facility also can send work orders and the work will be done. DHS reviews these systems and AMHI did well in 1987 and 2001 in those reviews.

The filters in the air system are changed quarterly and air quality in the hospital is tested annually. The nursing staff keeps daily logs regarding temperature. The staff can adjust the thermostat or the air conditioning units. The industry standard for temperature is 70-79 degrees. If 79 degrees is too warm, a clinical decision can be made to readjust the temperature. The thermostats are located in the corridor or in the nursing stations. The patients cannot adjust the temperature in their rooms. The maintenance staff makes adjustments within a certain range. There is a heat vent into each patient room. He agreed there was possibility of temperature fluctuation. The nurses take temperatures daily in five or six places in the facility but not in the patients' rooms.

In 1998, there was a concern about stale and stuffy air. An air quality management company tested and inspected the air quality. The results were not favorable and not up to industry standards. AMHI petitioned the Bureau of General Services for money and as of March 1, 2001, AMHI was in compliance. There was no explanation concerning why AMHI required three years to remedy this problem.

Housekeepers are assigned to the units. An executive housekeeper inspects daily. AMHI has an infection control nurse.

Secured storage space is available for patients in each patient area, in the basement, and in the bureaus in the patients' rooms. The standard size for single bedrooms is 100 square feet and 180 square feet for a double-occupancy room.

Prior to 1/25/02, AMHI purchased new furniture for the units. There is a visiting area in each unit. If more than one visiting area is needed, other rooms are available, such as rooms used for the groups, conference rooms, activity rooms, the music room, and interview rooms.

There are two pay telephone booths and a state line. The forensic patient have the state line only, which is not as private as the phone booths. Ms. Whitzell does not recall any complaints regarding access to telephones.

Although as the plaintiffs stated in their memorandum, concerns about the AMHI facility are nearly moot with the anticipated opening of the Riverview facility. The defendants have, however, shown that they are in substantial compliance with these paragraphs with regard to the current hospital.

C. Admissions

***130** Dr. Nelson testified regarding paragraph 145. He stated that AMHI has "for some months" been able to respond within thirty minutes of admission with a medical assessment. The chart, prepared from reports from Liberty Health Care Corporation, which hires the after hours physicians, is dated April, 2002. Dr. Grasso and Dr. Tedrick also addressed these issues.

The admission coordinator, Jim Champine, reports to Ms. Whitzell. He prepares the monthly admission reports. Ms. Whitzell was asked whether she did any follow-up on the 66 patients who were not admitted due to lack of capability. *See* Pls.' Ex. 6. She stated that she does not do follow-up. Jim Champine "at times" calls back to find out what happened to the person who was not admitted. She does not review these reports in any organized manner. AMHI does not have any method to track people who are not admitted. She agreed that 62 people not being admitted to AMHI was a concern. When asked what she does when she sees a report that 62 people have not been admitted to AMHI, she replied that she did not believe she did anything.

D. Treatment

Superintendent Kavanaugh testified that she was not the person to define counseling. She said there are written standards for counseling specific to each discipline, including nursing, social workers, and psychologists.

Superintendent Kavanaugh testified that not all of the

services listed in paragraph 155 were provided by AMHI to all patients who had a need for the services as of 1/25/02. She contends that AMHI contracts to provide the services or AMHI refers the patients; her contention is not supported by the evidence. In her deposition, she testified that this is a subjective evaluation.

Superintendent Kavanaugh testified that the Medical Director of AMHI would be more appropriate to answer questions about paragraph 158. As noted, Dr. Nelson did not testify about events prior to 1/25/02. She did not know whether AMHI kept track of patients not responsive to treatment who were referred to independent consultants. Again, she believed the Medical Director would be aware of that issue. With regard to paragraph 158, she testified AMHI does have a contract for neuro-psychological assessments but the Medical Director would know if there is any report identifying a patient who received a consultant.

Superintendent Kavanaugh was not aware of any specific document that would demonstrate compliance with paragraph 158 except the contract for neuropsychological assessments. Once again, she said these questions were better addressed to the Medical Director.

When asked whether she had requested data as a member of the AEC before a claim of substantial compliance was made regarding this paragraph, she testified that the AEC talked about the contract for the neuro-psychological assessments and referrals for ECT and medical assessments. She agreed that the treatment mall, implemented in 9/02, offers a wider array of choices for patients.

***131** AMHI is considering banning smoking in the new hospital but the decision has not yet been made. Currently at AMHI smoking is permitted inside but only in designated smoking areas. When asked whether no smoking policy would be consistent with paragraph 151, Superintendent Kavanaugh testified that she would deal with legal counsel. When asked whether it made sense to make a patient deal with a mental crisis and quit smoking at the same time, she testified that AMHI would not expect people to quit smoking immediately.

With regard to Acudose, a system used to decrease errors in dispensing medicine, Superintendent Kavanaugh agreed that Maine General has had this for four years but suggested that this system is not typically used in psychiatric hospitals. When asked whether medication errors were a problem at AMHI, she stated that medicine is always a concern. Medicine clearly should be a significant concern at AMHI

With regard to licensing and credentialing, AMHI has maintained JCAHO accreditation since the Consent Decree began and has been licensed by the DHS. The Superintendent did not know the licensing status but she assumed there was a license.

Dr. Nelson testified about paragraphs 151-159 and the Performance Improvement Plan and Treatment Mall.

As the Director of Nursing at AMHI, Ms. Whitzell is a member of AEC and a member of the team for performance improvement process. She is responsible to ensure the appropriate level of staff is available to provide nursing care, 24 hours per day, 7 days per week, including RNs, LPNs, and MHWs. She has two Assistant Directors of Nursing: one is in charge of staff development and educational programs and one is in charge of patient care services and support. The Program Service Directors reports to Ms. Whitzell. Each unit has a maximum of twenty patients and has a Program Service Director who is responsible for the unit.

Ms. Whitzell is responsible for programs, adequate staffing, evaluation of staff, and treatment plans for each patient. She is responsible to ensure that the unit meets the standards from JCAHO, licensing, and the Consent Decree and that the required information is in a patient's record. She is also responsible for maintaining the policies and procedures book for the nursing department in collaboration with the hospital procedure manual.

Ms. Whitzell testified generally about the services available at AMHI. Psychotherapy is offered to the patients by licensed psychologists and medical staff. Psychopharmacological therapy is provided by the medical staff. Two pharmacists dispense medicine and the nursing staff administers medicine. Social services are available. There are two social workers per unit and the mental health workers help with social services. Physical therapy is available only through consultation. Patients go to Maine General because there is no physical therapy AMHI. Occupational therapy also is available only through consultation. An occupational therapist visits AMHI, makes an assessment, and recommends a plan for the patient. Daily living skills training is available from the aides, nurses, and recreational therapists. Recreational therapy is available on the units and through the groups.

***132** Vocational/educational programs are available but vocational programs are more available than educational programs. Some patients have jobs at AMHI, such as cleaning up after meals and assisting with housekeeping. The patients are paid minimum wage. Some have jobs off grounds and are supervised. AMHI entered into a contract with regard to vocation programs. She did not know the date of the contract but thought it was within the year before her testimony; she did not know when any programs started.

Family support services and education are available through a social services department. Family support

education is also available. Substance abuse counseling is available through a contract with crisis and counseling. AA meetings are held at AMHI. One psychiatrist has a specialty in substance abuse counseling and one nurse has completed the requirements to be a substance abuse counselor.

Sexual/physical abuse counseling is available on as-needed basis. This is a long-term issue and patients are referred for counseling when the patient leaves the hospital. Instruction in principles of basic health care is available from the nurses and the MHWs.

AMHI has two dieticians and one dietary technician. A patient's dietary preferences are assessed on admission, as well as the patient's eating history and eating habits. The chart is reviewed with regard to diet and consideration is given to a patient's weight. Nurses and MHWs are involved if there are special considerations, such as diabetes. Needs that are out of the ordinary, for example, a choke risk, are noted in the treatment plan. Each patient has a card that lists all dietary information, presumably kept in the kitchen. If meals are unsuccessful, there is a plate waste monitor to determine how much food is returned uneaten. AMHI investigates if this rate exceeds 25%.

Other services available at AMHI include medical, surgical, and ECT (electric shock therapy). This need is identified by the treatment team and discussed with the patient. If the patient agrees to this treatment, the nurse fills out a consultation and makes an appointment for ECT.

Telephones and visiting rooms are available. When asked what monitoring system is in place to make sure that these things are treated as rights and not privileges, Ms. Whitzell responded that it is "common knowledge" that these are rights not privileges. AMHI has a system to grant privileges to patients based on a safety assessment.

The Program Service Director calculates individual counseling hours for nurses and social workers. Nurses do not have social work degrees. Ms. Whitzell was not able to speak to the definition of counseling for social workers. She assumed that the Program Services Director would use the same definition for social workers as for RNs. She did not give the Director any instruction regarding this issue.

According to Ms. Whitzell, individual counseling is charted and tracked in the patient medical records. The Program Services Director keeps track of counseling by nurses. The number of hours of counseling for patients is given to Ms. Whitzell and she gives it to the Superintendent of AMHI. The number of nurse hours of counseling is taken from progress notes and patient records and put into a computer. Psychologist hours of counseling are collected separately because those are billable hours. *See* Defs.' Ex. 16.

***133** A chart was created from the counseling forms for the period 1/20/02 through 10/12/02, a period not relevant to the issue of compliance. *See* Defs.' Ex. 76. Tracking of this data began last fall, according to Ms. Whitzell but she did not know when.

According to Ms. Whitzell, counseling by nurses is short, time-limited interaction, usually relating to problems, needs or behavior. *See* Defs.' Ex. 17, p.17 (definition of counseling for psychiatric-mental health nursing). Ms. Whitzell did not know when AMHI began tracking individual counseling hours but it was within the last two years. The December, 2001 progress report included no documentation to show compliance with the counseling requirements. *See* Pls.' Ex. 89, p. 50. Ms. Whitzell was asked whether she was contacted to give the Department information as part of the 12/01 quarterly report and whether she would have supplied documents. She responded that she could not explain why there was no documentation for the counseling requirement.

Documenting counseling hours has changed during the last year, 2002. In the fall, 2001, AMHI began using spreadsheets so that they could see the number of counseling hours for each patient. Ms. Whitzell stated that they were, at the time of her testimony, more diligent in reviewing the information weekly and could produce a report.

Her definition of counseling came from the policy and procedures and the standard for American Nursing Association. She defines counseling by nurses as short, time-limited interaction with individual patients, which is generally goal-specific and relates to problems or needs identified by the patient. When asked whether counseling would constitute a nurse asking a patient how the patient was doing or a nurse looking in on a patient sleeping, she agreed that was not counseling.

Counseling that is offered and refused is documented in a patient's chart. If a chart indicates that a patient refused counseling even for very legitimate reasons, that would still be considered an offer of counseling. There is no documentation in the chart or in any other place regarding the reason for refusal of an offer of counseling.

Ms. Whitzell believed, as do others at AMHI, that individual counseling may not be appropriate for every patient every day. AMHI is not required to do such individual counseling by JCAHO or DHS; the requirement is unique to the Consent Decree and is time-consuming to document. Ms. Whitzell was asked three times during her testimony whether AMHI believes that paragraph 156 is onerous and burdensome and she responded only that it is a time-consuming process. Ms.

Whitzell was asked whether the failure to report counseling hours was the reason that the Department thought it could not claim substantial compliance prior to January, 2002. She replied: "I think that might have been one of the reasons ." The reporting of individual counseling hours was an area of concern for the AEC.

The vast majority of hours reported pursuant to paragraph 156 involve counseling with nurses. Ms. Whitzell is a psychiatric nurse and considers all nurses at AMHI to be psychiatric nurses. She believes that training and education can be considered as a basis to be called a psychiatric nurse. According to Ms. Whitzell, all AMHI nurses are working within the specialty of psychiatric nursing. In spite of the fact that there is a certification for psychiatric nursing, Ms. Whitzell believes that if a nurse works at AMHI and goes through the training, the nurse is a psychiatric nurse. She did not know the number of nurses at AMHI who are certified as psychiatric nurses. *See* Defs.' Ex. 17, p. 13. She said that she did not know which RNs at AMHI had the two-year experience when they were hired. Paragraph 156 specifically refers to a "psychiatric nurse," which means an appropriately credentialed psychiatric nurse. Defs.' Ex. 17.

***134** She described the procedure for the admissions forms. The admissions coordinator completes the preadmission screening form (PASF) and puts it in the patient record. *See* Defs.' Ex. 27. Pages 1, 2, 3, 4 and 5 of the universal assessment are completed by the medical physician. *See* Defs.' Ex. 15B (in effect 1/25/02; *see also* Defs.' Ex. 15A, in effect within three months prior to Whitzell testimony). Pages 7, 8, 9, 10 are completed by the nurse. This form is placed in a patient's medical record in order to identify needs and form the basis for the treatment plan process. The team meets to develop a treatment plan including assessments, identification of needs, problems, and strengths. A goal is developed and it is determined what the patient will do and what the staff will do. A schedule is developed by the treatment team coordinator and given to the patient and the MHW on the unit. *See* Defs.' Ex. 14 (all post-1/25/02).

The PASF initial screening form is an important part of the treatment planning. *See* Pls.' Ex. 5. The compliance rate for completing the form in January, 2002 was 58% and in February, 2002, 50%. She receives these forms quarterly. There is no reason why she would not want to see them on a monthly basis but she does not ask for them monthly that frequently.

For an admission, the procedure provides that nurses leave the unit, go to the admission area and gather information for the PASF and the universal assessment nursing section. There is no requirement that the person who does this initial assessment attend the treatment team meetings. Attendance at these team meetings varies. At least a doctor, nurse, and social worker are expected always to be present but those may be the only people present.

In spite of the fact that Ms. Whitzell was consistently told that patients were not missing appointments, she was concerned that appointments were canceled due to lack of staffing. *See* Defs.' Ex. 13 (12/01-6/02). The first time any effort was made to determine why appointments were missed was August, 2002, when she developed a system. Information was collected daily by the staffing office to determine reasons for canceled appointments. Ms. Whitzell said it became evident that she did not know why appointments were being canceled.

A form for data regarding appointments was developed after January, 2002. *See* Defs.' Ex. 12. A second form was prepared in September, 2002 in an effort to figure out why appointments were being missed. *See* Defs.' Ex. 13. Ms. Whitzell first stated that she became aware of this concern about missed appointments in June, 2002. She then revised her answer because the Court Master had raised the issue two years ago. She then stated that she was aware of this concern for well over a year. She agreed that missed appointments are a problem at AMHI.

The testimony of the class members, Ms. Whitzell, Superintendent Kavanaugh, Dr. Grasso, Ms. McFarland, Mr. Ringrose, and Mr. Talbott show non-compliance with these paragraphs. Of particular concern is the failure to comply with the counseling requirement, which AMHI clearly believes is onerous and unnecessary. Further, the failure to consult any independent consultants regarding treatment, even when that treatment was not effective for extended periods of time, was not justified by the defendants.

Psychoactive Medication: Paragraphs 160-168

***135** Dr. Nelson testified about paragraphs 160-168. *See also* Testimony of Wisch, Grasso.

Ms. Whitzell stated that medical incidents errors are reviewed monthly. The review is done by the Director of Nursing, the managing nurse, the nurses leader for the team, the pharmacist, and the physician. This review been in place for two years; this "procedure" was, therefore, in place at the time of the medication error study.

In the beginning of 2000, oral reports of errors were made by the one responsible for the error or by another. In other words, the system essentially relied on self-reporting. The number of reports of errors was extremely low: five errors were self-reported based on 40,000 administrations of medicine. Ms. Whitzell met with the pharmacist and decided she might not be getting the true rate of error. They decided to redetermine the number of errors and present the figures to the pharmacist, the therapeutic

community, and the AEC.

In the fall, 2001, a study was designed by the pharmacist with a nurse practitioner. The study involved nine patients. After those patients were assessed, additional patients were added and the results were reported to the AEC, Ms. Whitzell, the pharmacist, and the Therapeutics Committee, and the Standing Committee of the Medical Staff. As a result of the study, Ms. Whitzell's department set up a committee to work on areas identified in the study. Forms were changed or eliminated including the PRN form and all records are reviewed by the 11 to 7 nurse, who checks all orders written the previous day. Further, the 11 to 7 nurse does a monthly review of ten charts. In response to the court's question, Ms. Whitzell admitted that this committee was formed in February, 2002.

AMHI's medical error study, done in the fall, 2001 revealed a "significantly higher rate of error" than Ms. Whitzell had previously thought. *See* Pls.' Ex. 10. The study revealed 45,900 annualized errors. *See id.* She agreed that this study showed a significant problem with medication errors. When asked whether she was aware of any reason why the study could not have been done two or three years before it was done, she responded that she was not aware of any such study nationally. She said she was not sure that it had ever occurred to the people at AMHI that a self-reporting system for tracking errors was fundamentally flawed.

General Health Care: Paragraphs 169-177
Dr. Nelson testified regarding the requirements of this section.

Ms. Whitzell testified about treatment procedure. Patients and staff meet in the patients' rooms or the treatment rooms. She does not recall receiving any grievances regarding appropriate places to meet. AMHI uses a system of flags to identify specialized needs in the charts. Stickers are available to indicate that attention must be paid to, for example, allergies, diabetes, a pacemaker, or a heat-related disorder. The charge nurse is responsible for making sure that all charts are flagged.

***136** Ms. Whitzell described the procedure for the incident report, which is used for unusual, out of the ordinary events that occur in the hospital. *See* Defs.' Ex. 21 (in effect 1/25/02). Each unit has a book of incident reports that are numbered and given to the nursing supervisor, the patient advocate, the Superintendent, and the nursing office. The clinical risk management nurse takes the reports, compiles the information, and forwards the information to those entities. Medical errors are included in the incident report. The physicians are to be made aware of a medical incident and the follow-up is done with the person responsible for the error by the Program Service Director or charge nurse.

The testimony regarding the medication errors is also considered for paragraphs 175 and 177. The testimony of the plaintiffs' thirty-second witness is considered for paragraph 173. Ms. Whitzell and Ms. Crommett's testimony about expected procedures is insufficient to show compliance with paragraphs 172 and 174.

G. Dental Care
Dr. Nelson testified about paragraphs 178 and 179.

H. Seclusion, Restraint and Protective Devices
Ms. Whitzell's staff is significantly involved in seclusion and restraint. RNs received information from patients on a safety form about what would be helpful to them; the patients may be extremely anxious or overly assaultive. All staff are trained in how to deal with assaultive behavior. The staff makes an effort to intervene with other alternatives. This procedure is in the policy manual.

The procedure includes the following. An assessment performed first by an RN and within thirty minutes, by a member of the medical staff. The person is placed in seclusion by an order of the medical staff. Seclusion can be for a maximum of four hours; restraints can be for a maximum of two hours. The patient is assessed by medical staff and is under constant observation while in seclusion or restraint. The RNs continually assess the patient and document the assessment in the record.

When the seclusion or restraint ends, a critique is done about what could have been done better, whether anyone was hurt, and whether the incident could have been prevented. The documents are reviewed to make sure all polices were followed. Documents are forwarded to the clinical risk management committee, the AEC, the medical staff, and the Court Master. Data are also submitted to NASMHPD. *See* Defs.' Ex. 23. This procedure was in place prior to 1/02 except for the requirement of constant observation if a patient is in seclusion and restraint; that revision occurred after 1/02.

There has been a decrease in the use of seclusion and restraint at AMHI since 1999. AMHI does not use protective devices. Sending a patient to his own room is an alternative to seclusion. The patient's room can become a seclusion room and all of the policies and procedures apply. No determination has been made by the AEC that negligent or abusive ordering of seclusion and restraint or protective devices has been used. *See* Defs.' Ex. 18. She believed that AMHI's seclusion and restraint regulations complied with the state and federal

regulations and that AMHI was in compliance as of 1/25/02.

***137** The Court Master was concerned in his testimony and his reports about the adequacy of the analysis of data on the use of seclusion and restraint. ¶ 189. The defendants rely on reports but the Consent Decree requires analysis.

I. Patient Abuse, Neglect and Exploitation

The plaintiffs do not challenge the defendants' compliance with these paragraphs.

J. Patient Injury and Death

The plaintiffs do not challenge the defendants' compliance with these paragraphs.

K. Staff/Patient Ratios

Dr. Nelson testified regarding paragraphs 202-204.

Ms. Whitzell testified about staffing theory. The Director of Nursing and the Director of Professional Services determine the level of staffing necessary for AMHI. The staffing is based on the acuity of patients. The staffing decisions are to be made based on what the units tell them regarding needs.

The nursing service policy and procedure manual documents requirements for care and specific procedures. *See* Defs.' Ex. 8. The policies and procedures are approved by Ms. Whitzell and the Medical Director. *See id.* p. 73372. Elements of psychiatric care include assessment, interview and observe patient and identify certain responses, hear their story, and see what brought them to that point.

Unit staffing should be based on patient census and actual patient needs, which is based on acuity factors. Extreme acuity factors require additional staff. Additional staff may be required based on medical needs or an appointments off grounds, including court hearings. The minimum level of staffing is based on the patient census. The day shift on every unit includes a minimum of two RNs. There is one nurse clinical coordinator and there is also an LPN to administer medication.

The staffing standard that governs unit staffing was updated in May, 2001. *See* Defs.' Ex. 11. There has been an increase in the number of MHWs, who assist nurses with the patient needs. The MHWs help with appointments, treatment plans, inter-shift methods of communication, and unit checks. All MHWs complete the CNA course or the mental health rehabilitation technician course. The MHWs are required to get a CNA license within six months of employment.

The role of a MHW has changed, according to Ms. Whitzell. They no longer have to do things that are done by ancillary help, such as cleaning floors, dishes, and housekeeping. They are now able to spend more time with the patients. The Consent Decree requires a staffing ratio of 1 to 6 for MHWs. A census of eighteen requires three MHWs and additional staff based on acuity factors. *See* Defs.' Ex. 11, p. 2.

In spite of Superintendent Kavanaugh's testimony that as of 1/25/02, AMHI was adequately staffed to fulfill the requirements of the Consent Decree, the evidence shows otherwise, particularly the testimony of Dr. Grasso and class members, which the court accepts as credible and reliable. In a statement of deficiencies dated 1/8/02, the DHS notified Superintendent Kavanaugh that it had found staffing inadequate at AMHI. *See* Jt. Ex. 13, p. 71924. The Superintendent responded on 1/28/02 with a plan of correction. *See id.* at 71927. She did not challenge the DHS's finding that the staffing was not adequate to meet needs. The DHS found the AMHI plan of correction unacceptable. *See id.* at 71935.

***138** Superintendent Kavanaugh agreed that mandatory overtime for AMHI staff has been in effect since before 1/25/02. All overtime includes voluntary overtime but some staff volunteer for overtime because they know it is mandatory and volunteering gives them some control over when the overtime occurs. Superintendent Kavanaugh agreed that mandatory overtime can affect employee morale although she alleged that she has no evidence that mandatory overtime affects the quality of care given to patients. That conclusion is simply not credible. She did not know whether anyone has to work double shifts but thought Ms. Whitzell would know.

Ms. Whitzell said that mandatory overtime was not a "policy" but a "practice" to assure that they can meet the needs of patients. She called it a "policy of mandating" when AMHI insists that a person work an extra shift. When asked whether as of January, 2002, AMHI was mandating overtime regularly to meet staff needs, she replied "that is possibly true." She said overtime had been a practice for as long as she had been at AMHI and it continued to the day of her testimony. She did not recall when mandatory overtime began.

Ms. Whitzell also alleged that the mandatory overtime does not affect the quality of care at AMHI. That allegation is rejected. She agreed that overtime affects the employees and employee morale. When asked how she could know whether mandatory overtime has an effect on the quality of care if she did not know when the overtime began, she replied, "I do not know how to answer that."

She agreed that AMHI has a high workers' compensation rate of reported injuries to staff.

Overtime could result in a double shift, which would last for sixteen hours with a one-half hour break between shifts. When asked whether a nurse might be tired during the fifteenth hour of a double shift, she replied that a nurse may be tired or may not be tired. She agreed it could happen that during the fifteenth hour a nurse would not be as interested in engaging with a patient but that fact would not appear on any form.

After mandated overtime is worked, an employee can work a regular shift as scheduled but the employee will be taken off the mandatory overtime list if she worked 72 hours of overtime. *See* Defs.' Ex. 10 (dated 1/27/02 and subsequent dates). If an RN works mandatory overtime, ten hours between shifts is required.

The Program Service Director reviews staffing with the staffing office. They do the review Monday, Wednesday, and Friday and during the interim if there is a concern. Ms. Whitzell did not know the percentage of patients who were able to move about the grounds freely, she thought 30% but that was a very rough estimate. Based on the testimony regarding mandatory overtime and missed appointments, her testimony that the patients' ability to get off of the units was not compromised by staffing levels is rejected.

Ms. Whitzell was asked what she would list if she could do anything to improve the quality of care at AMHI. She would add professional staff. She would also increase the ratio of RNs on the unit to make AMHI comparable to private hospitals. She would like 50% of the caregivers to be RNs; currently one-third are RNs.

***139** With regard to turnover, she said many nurses have been at AMHI for a number of years and she did not know the turnover rate for AMHI or for nurses. With regard to mid-level and upper-level management, she stated that some individuals had accepted other positions. Two Assistant Directors of Nursing have been at AMHI during 2002. A person was hired for MIS but left shortly thereafter. That person was replaced. The Medical Director position has turned over in the past year. The Medical Records Director left to work at another hospital in Maine.

The above testimony and the testimony of the class members, Mr. Talbott, and Dr. Grasso show the defendants' non-compliance with the staffing requirements.

L. Personnel

Dr. Nelson testified regarding paragraphs in this section.

Ms. Whitzell identified defendants' exhibit 9 as the required manual of job descriptions, qualifications, and competencies. She described the procedures for nurses and MHWs. MHWs during probation are evaluated and must attend an orientation with regard to all duties and functions of the hospital. Mental Health Rehabilitation I is a Department program that provides basic care skills for those who work in the mental health department. Background checks are done on the nurses and MHWs in Ms. Whitzell's department.

Nurses and MHWs are evaluated after six months probation, at the end of that first year, and then yearly. The procedure provides that if there are deficiencies, Human Resources tracks the employee and there is a plan of correction or disciplinary process. The disciplinary process includes counseling, written reprimands, and if appropriate, termination. AMHI's policy is based on the union contracts for professional and non-professional staff. If there are complaints, AMHI looks into the complaints, makes an assessment, and takes corrective action.

Nurses and MHWs are recruited by advertisements in the newspaper, job posting, and word of mouth. Nurses are encouraged to be part of the statewide nursing organization. There is no such organization for MHWs.

Nurses' salaries are reviewed annually and are determined by contract. AMHI has hired Dick's Consulting Service to compare salaries at AMHI with those throughout Maine. An RN statewide is paid $23 an hour; AMHI's RNs are paid $22.89. She agreed that working in a public mental health hospital could be particularly challenging and stressful.

For MHWs, the statewide average is $10 an hour; AMHI begins MHWs at $10.71. With regard to LPNs, the statewide is $13; AMHI pays $15 an hour although this may be because some LPNs have been there for a period of time. All employees also get the state benefit package.

For the past year, Ms. Whitzell has had multiple discussions with Human Resources to explore additional funding that could be given to the nurses. The salaries are ultimately approved by the Legislature. She always advocates for higher pay for the nurses. Ms. Whitzell did not believe that nurses' salaries were sufficiently competitive to permit AMHI to attract qualified candidates. She cannot offer sign-on bonuses and relocation pay. The central office was aware of the needs of nurses and the need to obtain a pay increase for all nurses and an increase in shift and weekend differentials.

***140** Lauret Crommett has been the Assistant Director of Nursing at AMHI since 10/15/01. She reports to the Director of Nursing, Ms. Whitzell. Ms. Crommett is in

charge of professional and organizational development.

Ms. Crommett described training procedures. The orientation for new employees involves eight, eight-hour days in the classroom. They receive orientation on all topics, including the Consent Decree, JCAHO, and OSHA requirements. *See* Defs.' Ex. 32 (after the tab "Introduction" are materials for nursing staff only). After this orientation, a one-week clinical orientation for nurses and MHWs and a one-week training on the unit where they will work take place. Training is mentor-preceptor based and competency based. If the nurses have completed the competency training, Ms. Crommett stated that the hospital "can tell" if the nurses are able to do the task.

Ms. Crommett states that a significant amount of training is done on seclusion and restraint. Reviews are conducted to determine whether employees are acting according to training. Debriefing occurs after each incident to determine what could have done better and what was done well. The risk manager uses the that information as a tool for improvement.

AMHI conducts classes and offers video and in-person training opportunities. People can attend grand rounds, including psychiatric and medical grand rounds, which occur weekly. Psychiatric grand rounds have been available since before her employment and medical grand rounds have been available within the few months before her testimony in November, 2002. *See* Defs.' Ex. 33 (7/19/01-8/10/02). The grand rounds are videotaped for review.

Journals are available as well as in-service training on the units. AMHI pays two-thirds of the tuition for college courses and pays for workshops. The pharmacy offers a presentation that "anyone can understand" regarding drug reaction; this presentation is for MHWs. There are additional courses for physicians.

When an employee receives training, a sign-in sheet is put into a database for each person's education sheet. The system is old-fashioned but can be used to get the statistics needed, including the individual reports and unit reports. The managers prefer individual reports in order to speak to employees to make sure they complete mandatory education.

Ms. Crommett developed the current system regarding training based on the requirements of the Consent Decree, OSHA, and JCAHO. All orientations are now given live with competency tests at the end. There is mandatory annual education for all employees. Mandatory training means that employees have to go to these sessions annually. *See* Pls.' Ex. 19.

Ms. Crommett wrote part of the December, 2001 progress report with regard to training. *See* Pls.' Ex. 16. Prior to 1/25/02, the computer program to document training was "not a good program," but individual employee records could be pulled up. According to Ms. Crommett, the compliance figures for training are 81% for clinical employees and 72% for all employees. These compliance figures were based on the data in the report and two people reviewing records manually to figure out who needed training and who did not. *See* Pls.' Ex. 16. No report was prepared as a result of this work; just "handwritten scratching." She saw the Court Master's report in which he noted the variability in determining compliance with training. She never sought to clarify that issue with regard to her figures. Even assuming these figures are reliable, they show minimal training compliance.

***141** She was asked to assess training when she arrived at AMHI and not within the month prior to 1/25/02. She assessed the education department and staff, including strengths and weaknesses and what was necessary to be done and when. They continue to need classroom space, teachers, supplies, furniture, a computer update, and secretarial help. She had no teachers at the time of her testimony in November, 2002 and no teachers have been hired. The position has not been authorized.

Plaintiffs' exhibits 17 and 18 are reports generated from the database. Plaintiffs' exhibit 17 is referenced in the Court Masters report of 12/31/01. Plaintiffs' exhibit 18 was included in the defendants' 8/02 compliance report. *See* Pls.' Exs. 17, 18. Ms. Crommett testified about the topics listed in plaintiffs' exhibit 17. Initially, she did not know what three of them meant. She then thought about her answer and finally did not know what PIEP (problem, intervention, effect of intervention on patient, and plan for the future) meant.

Training for psychiatrists is tracked only if the psychiatrist is an AMHI employees. Dr. Nelson, for example, is not an AMHI employee, but he is provided training opportunities. Physicians are not state employees.

She has never given a list of independent consultants retained by AMHI to be used for training. She had difficulty recalling when AMHI had used outside consultants to conduct training programs. She testified that in may instances, AMHI uses its own staff. She does not track compliance with paragraph 218 but she was sure someone else does that task.

AMHI does not track mandatory training for psychiatric and non-psychiatric aspects of responsibilities. ¶ 216 (second sentence). They track individual employee education attendance and give the information to the supervisors to see what should be done. She agreed that tracking training for trainers, who are employees, has been a documentation problem.

The testimony of Mr. Talbott is also considered on the issue of training. Once again, procedures do not show compliance with requirements. The testimony of Ms. Crommett did not instill any level of confidence that these issues were appropriately addressed by AMHI.

M. Patient Records

Ms. Whitzell stated that nurses document anything unusual and document ongoing interaction. The format used is PIEP, with which Ms. Crommett was unfamiliar. She stated that nurses "know" when to enter a note on the record based on general nursing practice and on AMHI's policies. With regard to legibility, everyone "knows," according to Ms. Whitzell, that notes should be legible, dated, and timed. Two years before the date of her testimony, a nurse educator was hired to provide ongoing education for the staff to increase the quality of documentation.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 143-147, 150-156, 158-168, 170-179, 189, 202-204, 206 (physicians; dentists; social workers), 208 (physicians; dentists; social workers), 209 (physicians; dentists; social workers; nurses), 211 (physicians; dentists; social workers), 213-215, 216, 217-219, 221-222 of the Consent Decree.

X. STANDARDS GOVERNING TREATMENT OF MINORS: Paragraphs 224-235

***142** The plaintiffs do not challenge the defendants' compliance with these paragraphs.

XI. STANDARDS GOVERNING TREATMENT OF NURSING HOME PATIENTS: Paragraphs 236-249

The plaintiffs do not challenge the defendants' compliance with these paragraphs.

XII. STANDARDS GOVERNING TREATMENT OF FORENSIC PATIENTS: Paragraphs 250-251

The Department's general obligations apply to forensic patients as well as to other patients, including a timely discharge. *See* Paragraphs 32(d), 75-81. Mr. Rodman believes, and the evidence supports the conclusion, that these obligations are not being met with regard to forensic patients. Mr. Rodman believes correctly that the principle that people should be released from AMHI as soon as they do not need to be in the hospital is embedded in the Consent Decree and that such timely releases are not occurring. Although paragraph 250 provides that forensic patients will be discharged according to statute, they are not excluded from the treatment procedure that leads to discharge.

Barbara Cox is a psychiatrist and the Clinical Director of forensic unit at AMHI, where she has been employed since 1988. Her job responsibilities include supervising the consulting services for the forensic patients on the civil units and consultant to the hospital for forensic patients. For paragraph 250, the Superintendent relies on DHS and JCAHO standards. Those standards do not address the forensic unit but require a standard of care. *See also* Jt. Ex. 4; Defs.' Exs. 80A & 80B.

The legal status for forensic patients on the unit include: (1) those determined not criminally responsible; (2) those awaiting evaluations for competency to stand trial and criminal responsibility or those found incompetent to stand trial; (3) transfers from the jails; (4) on rare occasions, patients who cannot be managed on the civil units. At the time of her testimony, there were nine NCR forensic patients and one transfer from a jail. All the forensic unit patients were male.

All forensic patients are admitted to section three, the maximum security unit. They move to medium security if they can handle increased stimulation. The medium security unit has a lower staff/patient ratio. There is a decrease in levels of staffing as the patients move from medium security to other parts of the hospital and the grounds. In theory, the patients can go onto the grounds of AMHI with staff who are familiar with the patient. If the patients are unsupervised, in a group or on the grounds, they must check in at the security booth every half hour.

The most acute patients are placed in the maximum security unit. There is low stimulation on that unit and a high staff/patient ratio. These patients also move to medium security unit once they are stabilized.

According to Dr. Cox, in general, except for specific safety and security concerns, the forensic patients are treated the same as other patients. This opinion is not accepted, based on the testimony of the class members and Dr. Grasso. The forensic unit staff receives the same training regarding treatment of patients but receives additional training on forensic issues.

***143** Either Dr. Cox or a mid-level staff person attends all treatment meetings. She runs a group on the unit and is frequently present on the unit.

As of 1/25/02, according to Dr. Wisch, AMHI had no groups for personality disorder and empathy skills or for criminal thinking. A dual diagnosis group and a radical acceptance group run are available to forensic patients.

The statute requires privileges, including leaving the

grounds, for patients at AMHI who transfer from the jails. If a forensic patient wants to leave the AMHI grounds, that issue must be reviewed by the court. Forensic patients, when psychotic, are more at risk for injury so increased level of security is required. There are two treatment teams on the unit. Case conferences and safety and security meetings are held on a weekly basis, in which staff considers how the patient is doing, treatment issues to focus on, concerns regarding helping the patient to improve, and impressions. Level reviews are referred to the Medical Director and the Director of Nursing. The entire focus of treatment is returning the patient safely to the community.

Dr. Cox testified regarding several forensic patients. The first was moved from maximum to medium security within five to ten days of admission. He was in AMHI because he was NCR for the crime of murder. He was on medicine when he arrived and was not threatening. He was at AMHI for fewer than one and one-half years. He returned to court and was allowed supervised time in the community.

The second patient made no progress for some time. He had visits with the staff but he feared what would happen if he left the unit. He was afraid he would drink although the staff reminded him that he would be supervised if he visited the community. He now spends unsupervised time on the grounds and is doing well.

The third was, according to Dr. Cox, an example of a patient who does not progress. He is NCR on various charges. He was at AMHI previously before the NCR finding. He had been on the medium security section for several years. He was being treated with anti-psychotic medicine and he was unwilling to try any other medicine. AMHI had an administrative hearing in order to give him medicine involuntary but did not prevail. He was quite psychotic and paranoid and had made threatening comments. This patient cannot have unsupervised time.

Dr. Cox writes the annual psychiatric assessments, which focus on each patient's status, why the patient is in AMHI, the patient's medical and substance abuse history, historical data, a mental status evaluation, thought content, a review of how the patient has done through the past year including hurdles and difficulties he has overcome, and anticipated treatment. The annual psychiatric assessments of the patients were not current at the time of her testimony and had been late since June, 2002. She works extra hours to do those reports and has discussed this with her supervisor. Many reports were due at the same time and she was not able to focus on the psychiatric assessments.

***144** She was asked to prepare a report about NCR patients for Commissioner Duby. She reported on the services received, how the patients were doing, and whether they were safe to be discharged. She does not know why she was asked to prepare this report; she had never been asked to do such a report before. Although she was asked to compile the report one and one-half years before her testimony, she had just begun the report six months before her testimony.

AMHI or the patient can request expanding levels. More than 75% of these requests, probably 90%, are initiated by the patient. The patients generally have higher expectations of the levels they are ready for than the staff. When a request is made, AMHI prepares a report. With most if not all the requests, Dr. Cox recommends an increase in the levels and privileges. AMHI's mission is to increase the levels as fast as possible consistent with safety concerns. If the patient's request for increased levels is denied, the patient cannot return to court for six months.

With regard to the review process in the hospital, the treatment team makes recommendations, which are then sent to the safety and security committee, which meets weekly. A report is prepared for court, usually within four weeks, and submitted to the Superintendent, the Director of Nursing, and the Medical Director. The report is reviewed, usually within one week, although the review can take longer. Previously, a hearing was not scheduled for six months; that time period has now been reduced. Their appearances in court have increased during the four months prior to her testimony.

There are five males and four female forensic patients housed off the forensic unit. Females are always housed off of the forensic unit because there is no forensic unit for females. The forensic patients who are not housed on the forensic unit go through the same process to increase levels. The treaters in their units do not, however, have as much experience writing the reports so they ask for assistance from the forensic unit staff. The forensic safety committee is not as familiar with the patients who are housed off of the forensic unit but the staff members who know the patient attend the patient's meetings to assist.

The ability of a forensic patient to get off the unit depends on the staffing level; if they had more staffing, more patients could get out on a more frequent basis and for longer periods of time. She had not participated in any study to determine what staffing level was necessary to get the forensic patients off the units. Data are not collected on that issue.

The Consent Decree states that civil patients cannot be admitted to the forensic unit except for some exceptions, which have been negotiated, including patients with ongoing assaultive behavior, patients who demonstrate a risk to specific people, and legal hold patients who no longer meet the criteria but are willing to stay on the forensic unit. *See* Pls.' Exs. 12-15. Dr. Wisch discussed

one patient for whom he was the treating therapist from the fall of 1999 to the beginning of 2001. This patient was voluntary civil patient and resided on the forensic unit, section three, which is the high security section, for approximately ten years. His history included very serious, multiple assaults against women, and a potential for violence. His treatment included medicine to treat psychosis because he was psychotic most of the time. The placement on section three insured his safety and the safety of others and minimized his contact with women.

***145** Both Dr. Wisch and Dr. Grasso provided services to this patient and discussed the advantages of leaving the forensic unit. The patient did not want to leave section three because it was the only place he felt safe. Female staff members were introduced for section three and they tried to get him out in community with men and women to demonstrate that he could manage himself. It was difficult to predict whether he would be dangerous. Ultimately, the treatment team decided to take a risk and encouraged strongly that he move to Stone South Middle. He agreed and has been there ever since. At the time of Dr. Wisch's testimony, AMHI was working on moving that patient out of the hospital.

Dr. Cox admitted that, as of January, 2002, a caseworker was not assigned to forensic patients upon their request unless the patient was in reasonable proximity of discharge. The date for assignment of a caseworker depended on the patient and the time required for the caseworker to get to know the patient. If AMHI did not foresee problems, the caseworker would be assigned essentially at discharge. Dr. Cox admitted that there was some confusion regarding discharge planning.

Susan Whittington testified that if forensic patients are in the hospital for more than 90 days, a decision is made regarding when to assign a caseworker She did not know when this change in policy occurred. That policy regarding forensic patients is not included in the ISP Training Manual. *See* Jt. Ex. 23, p. 38.

Superintendent Kavanaugh was asked whether as of 1/02, AMHI had a different policy for requests for caseworkers for forensic patients at AMHI as opposed to other patients. She was not sure whether there was a policy. The decision was based on a determination of whether a caseworker was appropriate for the patient. Dr. Wisch revised a policy regarding caseworkers for NCR forensic patients about one month prior to his testimony. *See* Defs.' Ex. 41, p. 32. Dr. Wisch agreed that forensic patients are among the more than 150-day patients. *See* Defs.' Ex. 30.

AMHI assumed that when a change from forensic to civil occurred, the patient could continue on the forensic unit while the discharge proceeded. In March, 2002, AMHI understood that the patient had to agree and the policy was changed.

As of 10/23/01, the criminal charges were dropped against one forensic patient, who had been determined to be incompetent to stand trial. He was admitted to the forensic unit as a civil patient. As of 11/1/01, Dr. Cox read and cosigned all the notes written by the mid-level staff person she was working with. The last paragraph of the 11/1/01 note states that it is AMHI's decision where the patient will be housed; the Consent Decree requires that this is the patient's decision. This patient stayed in the forensic until as a civil patient until 11/20/01. *See* Pls.' Ex. 13.

A second forensic patient had previously been a legal hold and was admitted to the forensic unit as a civil patient. Dr. Cox did not sign this note. *See* Pls.' Ex. 14. As of 4/3/02, the sentence in paragraph 11(1) of the defendants' policy was added to provide that a patient will be offered an opportunity to transfer out of the forensic unit unless he indicates a preference to remain on the forensic unit. *See* Defs.' Ex. 78.

***146** AMHI does not include forensic unit patients in class member survey. The January, 2002 hospital consumer survey did not include the forensic unit patients.

The testimony below of the class member forensic patients further confirms that the defendants are not in compliance with the provisions of paragraph 250.

The incident that brought Stacy to AMHI occurred on April 11, 1999. *See* Pls.' Exs. 48, 49. She was blue-papered to AMHI on 4/12/99 and discharged to a group home on 9/1/99. In January, 2001, she was found NCR after trial and was then admitted to AMHI on 1/10/01. Because she was NCR, she could not go back to the group home because of different standards, even though the group home held a bed for her. She had a CSW when she was in the group home and met with the CSW two times per week. She also had individual therapy, a job, unstructured activities, a vehicle, and appointments. All of those things ended when she could not go back to the group home.

She has lived on Stone South Middle since January 15, 2003. Previously, she lived on Stone North Lower and had her own room. She is in a dorm now with two patients, one civil and one forensic. One roommate screams and throws things and is very disruptive. Stacy uses earplugs to try to sleep. The civil patient roommate has a medical condition, which requires that this patient be awakened several times during the night.

At the time of her testimony, Stacy had no privacy. There was no place for her to go to do anything, even if she wanted to cry. She had no choice in her room and was

told that she would receive a private room when one was available. She is still finding it really confusing to try to adjust to Stone South Middle. When she moved to Stone South Middle, everything changed for her except her psychiatrist and psychologist. Time frames are different and the civil patients have different rules.

Stacy also had no access to exercise. She used to go to the gym every morning. Because mandatory attendance was required at the Treatment Mall every day, there was no alternative time for the gym.

She was not involved in determining her treatment plans. She did not recall discussing any new treatment team plan with the new team. She had not seen a treatment plan during the two weeks since she moved. Goals were set for her by her psychiatrist.

Stacy said that it takes quite some time to get an increase in privileges. It can be a matter of weeks or even a month before she gets "her level back." Her treatment team determined the level she was ready for and submitted papers to the forensic unit. She had meetings with the forensic team but she did not know those people well. She hoped that someone from her team would accompany her to those meetings.

The AMHI staff does not initiate the effort to take patients off the grounds. The staffing levels affect the staff's ability to take her places. She called her attorney and always has had to petition because if she relied on the hospital, this would never get done. She said that she has a good attorney and can ask for what she wants, but some patients can not.

***147** Getting a court date can take weeks to months. Her last papers were filed in the beginning of September; she went to court 10/31 and received the right to go off grounds. There was a delay after going to court in getting the privileges that were granted; that had not happened as of the date of her testimony.

She wanted to take a computer science class off the AMHI grounds. On 1/9/02, she went to court to obtain approval to take the class. AMHI said that it did not have the staff and she was not approved to go on her own. AMHI also said that it would not pay for the class. She could not go to the class so she went to work.

Stacy does not have a CSW, although she would like to have one. One year before the date of her testimony, she asked for a CSW or an ICM and filled out the paperwork. One month later, her request was denied because she did not have a discharge date. She has not applied again because she has not received a discharge date. Because she is supposed to make progress regarding integration back into the community, she believes a CSW or an ICM would help.

Stacy does not file grievances often because she believes they are pointless. If she files them, she considers them a record. AMHI basically says "thank you for bringing this to our attention." Further, she does not want to suffer repercussions or delay because she has filed grievances.

Stacy was asked by defendants' counsel whether there was any continuing benefit for her to be at AMHI. She responded that that question put her in a very tough spot because the Superintendent of AMHI was sitting in the courtroom. The question was withdrawn.

AMHI can be a very frightening place for Stacy. She finds living at AMHI like being in a maze; she does not know really how to get out. She does not have a clear idea of what she has to do to get discharged now. Her form says "indefinitely" for the time of her stay. She has goals but does not know what the expectations are. She is trying to navigate through a maze and she does not know where the end is.

Dana Blaisdel is a forensic patient at AMHI. *See* Pls.' Ex. 52. He asked to be subpoenaed to testify because he was concerned about his future at AMHI if he testified.

He has been at AMHI for one and one-half years. At the time of his testimony, he had been at Stone South Middle for three weeks. He felt safe there. Previously, he was on the forensic unit, where he did not feel safe due, in part, to a shortage of staff. As with Stacy, he lost all of his usual staff when he made the change to Stone South Middle.

He also does not like to file grievances. He has filed only one and he knew it would go no farther than to the Program Service Director.

He is trying to get discharged from AMHI. He has met all of his goals and looked forward to going to a substance abuse facility but there was no space available for him at the time of his testimony.

He has no CSW, although he would like to have one. He has never had a CSW and has never been offered a CSW.

***148** The forensic unit staff did not help him have visits with his son, who is very important to Mr. Blaisdel and with whom he had established a relationship. The staff had taken him to see his son twice during his one and one-half years at AMHI. His son's mother can bring his son to visit at AMHI, but Mr. Blaisdel has to pay $30.00 for her gas and food. If he had the money, he would see his son more often.

Kirk Lambert has been at AMHI on the forensic unit since winter, 2000. He just received a new treatment plan. He said that when the AMHI staff learned that he was going to testify at the trial, there were "people chasing around

after him with clipboards." He had an "ancient" plan previous to this new plan.

He was involved very little in shaping his treatment plan. The staff made decisions about his goals and how he should reach them.

He also did not get an adequate chance to exercise. The gym program ended when the Treatment Mall began. The staff promised to find another time available for the gym but that had not happened at the time of his testimony. He was overweight; he needed exercise and he needed the release. He had seen many forensic patients lose their chance for activities because of staff shortages.

At the time of his testimony, he did not have a CSW, although he would like a CSW because he would like to try to work on re-integration into the community. He was never offered a CSW.

He does not have a high school education. He took GED courses at the Kennebec County Jail. He told AMHI that education is an important goal for him. One and one-half years ago, AMHI promised to develop a GED program but AMHI has done nothing to help him get his GED. He figured this is now another thing that he will have to do on his own when he gets out.

He thought he knew what would be required to be discharged but he was going "around in a circle." He thought he would be discharged before the new hospital opened but he could not get a direct answer to his direct question. He would like to know how much more work he has to do on stabilization, understanding his illness, and issues of safety to others and himself.

Alexander Knee had been at AMHI for two years on the forensic unit. *See* Pls.' Ex. 51. He stated that he tries to stay out of trouble. He had a psychiatrist whom he saw once every two or three weeks. He did not have a CSW, although he would like to have a CSW so that he can be a better person and stay on his medication when he is on the outside. He had asked for a CSW or an ICM last summer but the request was denied because he did not have a treatment plan.

He had a treatment team meeting during February, 2002. They talked about discharge plans but the AMHI workers have said that before and nothing has happened. He does not have a clear understanding of what is required for him to be discharged.

As with the other forensic patients who testified, he had no access to exercise, except for walking outside. The level of staffing affected his ability to get off the unit.

***149** He had filed many grievances, which he described as worthless. He last filed one regarding air temperature. His plants died in the winter because of the drafts through the windows. When this problem was addressed, the windows were fixed in place so they could not open. In the summer, it was very hot because he could not open his windows. He also has filed grievances that disappeared.

Mr. Knee is an artist and has won awards for his art and crafts. The last grade he completed, however, was the seventh grade. He dropped out in the eighth grade and went to jail. His goal is to get a GED. He reads at a fourth grade level. He is dyslexic and has a phobia regarding reading. He requested to have a private tutor and he was willing to pay for that. He told AMHI one year ago in a levels meeting that he needed help learning how to read and to get his GED. The staff said it would have to bring the issue to the administrator and he never heard back. He has received books on tape, but no other help from AMHI regarding his GED.

This issue was very important to him because he had gone through most of his life without reading. He saw people reading and he wanted to do the same thing. He enjoyed reading read about planes, boats, and science fiction. He had never accomplished anything in his life and his GED was important to prove to himself that he can do it.

All of the AMHI Consent Decree standards apply to forensic patients. Failing to give them CSWs, discharge plans, and any understanding of how to negotiate the "maze" is of significant concern to the court.

As of 1/25/02, the defendants were not in substantial compliance with the requirements of paragraph 250 of the Consent Decree.

XIII. PUBLIC EDUCATION: Paragraph 252

Katherine Sanborn was an Assistant Commissioner at the Department from 8/29/01 through 11/01/02. Her responsibilities were to track activity that occurred regarding public education and she was the lead for legislative and media relations. She compiled the quarterly report that was given to the Court Master regarding public education. When she was hired, she understood the scope of the job with regard to public education was to receive and compile information from NAMI, the QICs and Regional Directors. She prepared a form for information. She reviews the forms and writes reports.

The Department has a contract with the NAMI with regard to education. *See* Defs.' Ex. 87 (7/1/01 through 6/3/02). Rider A, page one of Ex. 87 provides the services to be performed by NAMI and includes education and training. Page three provides the information and referrals. Educational materials available from NAMI.

The Department funds the QICs' efforts to educate at the local level. The QICs include Kennebec/Somerset, West Region, Coastal Region, York County, Cumberland County, BMHI, and AMHI. NAMI is the fiduciary agent for the QICs and oversees fiscal aspects of reimbursing QICs for activity at the local level. NAMI will provide quarterly reports according to the Department's specifications. *See* Defs.' Ex. 88A-C; Defs.' Ex. 87, Rider A, page 1. If she had questions about the reports, she called the regional office or NAMI but everything was usually "pretty clear." She had never verified or tested the data she received. She used the reports for her quarterly report to the Court Master.

***150** She also received reports from the QICs bi-annually. *See* Defs .' Ex. 89. The Department has no contract with the QICs for this work but there is an agreement that they would report. She sent a reminder to the QICs about reports in the spring of 2002.

She was not specifically aware of any policy or requirement that mandated the frequency or format of reporting regarding education.

Efforts had been made to enhance the Department's web site. The Department's directory of services had been put on the site, can be downloaded, and was user friendly.

She had worked in each region of the state to develop public service announcements. These were to be aired from October, 2002 through March, 2003 in five movie theaters: Ellsworth, Bangor, Lewiston, Waterville, and Brunswick. The public service announcements were developed in the spring, 2002 based on focus groups. Posters with the same message were also to be used.

She put together announcements and news releases for the media. After September 11, 2001, she prepared a press release regarding a crisis help line so that people could call to talk about feelings regarding 9/11.

The regional offices conduct public education. Region I has hosted business forums to educate business leaders. Information has been on Maine Public Radio and in the Portland Press Herald. A number of trainings and educational efforts occurred through several parts of the Department; it is "sort of everyone's job" to provide education and information.

The budget for public education is provided through the contract with NAMI. She thought it was in the hundreds of thousands of dollars but beyond that, she was not able to specify amounts. She did not know whether she was given a budget for public education. She made no recommendations regarding the budget for public education and she did not recall being asked.

Education is part of what the QICs do but they have other functions. Each QIC received approximately $10,000 a year. She did not believe the QICs had to allocate any of that sum for education but "not all education costs money either."

When asked whether before 1/25/02, she required or requested outcome-based reporting and evaluation by QICs regarding public education, she answered that she could only go on reports and she saw them when they arrived. Both quarterly reports for 10/01 and 12/01 contain the same paragraph: "In order to monitor the outcomes of these [public education] projects, the Department, through the contracting process, will move to require outcome-based reporting and evaluation of public education efforts." *See* Pls.' Exs. 34A & 34B. Ms. Sanborn was responsible for writing these reports. She could not speak to the contracting process. In spite of that language, Ms. Sanborn does not believe that paragraph 252 requires outcome-based reporting: there is no requirement, she believes, to evaluate the effectiveness of public education.

She was unaware of any specific educational efforts that had been made to educate the public regarding rights consumers may have under the Consent Decree. She did not have any direct dealings with class members and she did nothing to target information to the class members. She thought people in central office would deal with effort to educate class members who are not getting services about their rights.

***151** She was not aware of the annual consumer survey and she did not consider the results of the survey relevant to her responsibilities. She made no requests to the Department to ask consumer satisfaction questions on the survey regarding the requirements of paragraph 252.

During the fourteen-month period of her employment in this position, she was not aware of any surveys for the general public undertaken to ascertain their understanding or lack thereof regarding mental illness. She measured the effectiveness of efforts to educate the public regarding the myths and stigma of mental illness by determining the number of people reached, the type of activities held, the number of pamphlets distributed, and the number of trainings held.

She said the Office of Consumer Affairs, where she worked, controlled the money for public education. She was unsure of the amount budgeted but thought it was approximately $25,000. She did not know how that figure was determined to meet the requirements of paragraph 252.

She had never hired a marketing consultant to meet the objectives of paragraph 252. There was no priority regarding how to spend funds to reach effectively the most people. She said she simply carried on with

activities she knew had been in existence.

She believed that receiving the reports from the QICs about what was going on, who was reached, the units of training given, and the number of people reached was sufficient to meet the paragraph 279 requirements for public education.

In the fall, 2001, she worked with Brenda Harvey to evaluate whether the Department was in substantial compliance regarding the public education requirement. She worked to compile information received but she did not specifically make a judgment regarding the adequacy of the Department's efforts because she had only been with the Department for one month.

This witness clearly had no idea about the requirements of paragraphs 252 or 279, about whether the Department was budgeting for public education, or about whether the Department efforts were effective. She sent a form, she received a form, she read the form, she filed the form.

The testimony of this witness underscores the defendants' fundamental assessment of the requirements of the Consent Decree: if they have numbers and policies in place and reports are filed, the effectiveness of those policies or the meaning of those numbers or reports is not required to be addressed.

As of 1/25/02, the defendants were not in substantial compliance with the requirements of paragraph 252 of the Consent Decree.

XIV. DEPARTMENT OF HUMAN SERVICES PUBLIC WARDS AND ADULT PROTECTIVE SERVICES: Paragraphs 253-261

Christine Gianopoulos works for the DHS and is the Director of the Bureau of Elder and Adult Services. She reports to the DHS Commissioner. Her job responsibilities include providing overall direction and management for programs and services. The services include adult protective services and public guardian programs, home and community based programs, long term care, pre-admission assessments, certification of need review process, disability determination services, and state long-term care.

***152** The DHS has 146 class member public wards and two class members for whom the DHS has conservatorship. The total public ward cases total slightly over 700, which includes class members and non-class members. The public guardian role is determined by the guardianship order, which is signed by the Probate Court. Usually the guardian determines where the public ward lives and helps with management of financial resources. Her staff is expected to participate in the ISP meetings and attend treatment and discharge meetings. The services provided include housing, financial, contact with family, and participation in the ISP processes. All class member public wards should be offered an ISP. The DHS has no specific policy in place if a class member public ward does not want an ISP. That situation is handled on a case-by-case basis and the case worker would consult with the public ward, the supervisor, and other providers. Fewer than twelve of the 146 class member public wards do not have an ISP. ¶ 254.

Training includes informed decisions, best interests, and risks of medical procedures. New caseworkers receive training in all aspects of the Consent Decree requirements, including the requirements of paragraph 255. Generally, decisions involving medical procedures require supervisor involvement.

Based on the case review, the Bureau knows that some caseworkers are not making the required two visits per month. Sometimes the visits occur but are not documented; sometimes the visits do not occur. Supervisors are expected to remind the caseworkers to make the required visits. The plaintiffs did not, however, contest paragraph 256.

The Bureau policy manual contains a policy about the requirements of paragraphs 258 and 259. The caseworkers are trained on these paragraphs as part of the Consent Decree training. In case reviews, the Bureau looks for documentation of these requirements. The Bureau looks for a copy of the annual letter advising the public wards of their right to petition for termination of the guardianship and of the availability of advocacy and peer assistance.

Caseworker services to class member public wards are monitored through supervisor meetings and case reviews. A random sample of cases is reviewed quarterly and the review includes at least one case from each caseworker. An additional three cases are reviewed for each quarter for those caseworkers who have a caseload of more than 25 cases. The central office and the supervisor for the caseworker whose case is being reviewed do the reviews. She agreed that there is no guarantee that a class member's case would be reviewed but a sufficient sample is included every year. They review a 10% sample of all cases, which somehow is understood to provide a 10% review of class member cases. Additional reporting requirements to the Court Master include this information. There is also a protocol for reporting certain types of critical incidents, which are investigated by the caseworker and, if necessary, the supervisor.

***153** The procedure provides that all new employees receive a standard orientation and receive six hours of videotape training about the Consent Decree. Ongoing

training is provided by the supervisor and the staff of the central office assigned to the Consent Decree. An annual update is conducted with regard to policies and practices regarding the Consent Decree.

Approximately 25 caseworkers serve the class member public wards. Their caseload is monitored on a monthly basis through the monthly caseload reports. The caseload size is required to be 1:25. During the last year, especially in Southern Maine, some caseworkers had more than 25 cases. *See* Jt. Ex. 26. Two caseworkers in Biddeford had 26 cases at the time of her testimony, although the Bureau expected to remedy that situation with a new position. ¶ 257.

Two Legislative sessions ago, the Bureau requested and received a new caseworker position. During the last Legislative session, the Bureau requested and received two caseworkers. The Bureau told the Legislature the positions were needed to permit the Bureau to stay in compliance with Consent Decree. These positions were exempt from the hiring freeze.

Ms. Gianopoulos agreed that at the time the defendants filed the notice of substantial compliance, they were not in compliance with regard to the caseload requirement. They expected that they could come into compliance with the new caseworker position but did not because they could not hire the person. She agreed that "we were wrong" in their assessment regarding substantial compliance. Because noncompliance with the requirement continued, they requested two more caseworker positions in the last session. These caseworkers had not been hired and the caseload continued to grow. The Bureau continued to state, nevertheless, that it can come into compliance.

The Bureau has developed a number of residential programs to serve class member public wards and other class members with brian injury and dementia. The Bureau works in existing nursing homes to convert them to specialized Alzheimer facilities or the Bureau requests special funding for Alzheimer facilities or programs for public wards. The geriatric population receives home-delivered meals, transportation, home care, and guardianship services. Eligibility is determined on a functional and financial basis. The class members' eligibility differs from eligibility for others.

The Bureau takes responsibility for all class members who have traumatic brain injury and not just public wards. Some class member public wards with brain injuries are receiving services at Lakeview. Lakeview is a provider under Maine Medicaid and the programs are administered under Maine Medicaid. Lakeview is expected, pursuant to the contract/provider agreement, to adhere to all Medicaid policies. She stated that the public wards at Lakeview should be seen as often as those in Maine. The testimony of Ms. Diamond made clear that this expectation is not fulfilled.

***154** Complaints are investigated. Through this process, apparently, the Bureau determines that the quality of care at Lakeview is the same as in Maine facilities. Ms. Gianopoulos did not know how many class members who are not public wards live at Lakeview. She expected that all would prefer to live in an in-state facility.

The Bureau also works with the Brain Injury Association, with the Maine Alzheimer Association, and with people experienced in working with these populations. These individuals sit on review panels for RFPs. The Bureau has a contract with an occupational therapist and a contract with persons who have experience in the area of working with people with brain injuries and with Alzheimer patients. ¶ 87.

She is involved in planning and budgeting for the DHS. She relies on her own information from day to day experience in serving public wards, caseload tracking, information from families, and information from service providers who work with the public wards. The Department and the DHS have a joint advisory committee on elder services.

Information about the number of class members living in New Hampshire has not been given to her by the Department. If that information had been given to her, she would have used it in developing the budget. In the last budget, the Bureau requested funding based on information from families and the brain injury services.

As the result of the amendment to paragraph 96 in February, 1996, the Court Master can issue a waiver of the eight-bed limitation. The Bureau has developed homes with eight beds, fewer than eight, and more than eight. The Bureau has number of facilities for Alzheimer patients, which have more than eight beds. A unit in Riveridge, New Hampshire also has more than eight beds; she did not know whether class members live there. The Bureau tries not to place class member public wards in a facility with more eight beds but some are in facilities with more than eight beds. The goal for class members is a setting that is best for them.

Court Master approval is required to place class members at the Mt. St. Joseph's facility. Ms. Gianopoulos expects the caseworkers to discuss whether a person wants to live there, but she considers the requirement waived. Accordingly, when they do reviews they do not look to see whether the client was advised of the right not to live there. At Mt. St. Joseph's and at nursing homes where there has been a waiver, she concluded that the clients have no right not to live there. This conclusion is contrary to the clear language in the 2/16/96 order.

She is also responsible for licensing of assisted living services in residential facilities. The RRMHS are incorporated by reference into the licenses of assisted living services. Their surveyors review for compliance with the requirement that any violation of RRMHS is reported to the DRC. She said they do not review the other requirements of the RRMHS because the licensing rules state specifically that those requirements are to be enforced by the Department. The Department's staff does not accompany her on license reviews of assisted living centers.

***155** Ms. Gianopoulos was sure that class members reside in assisted living centers in facilities licensed solely by the DHS and not by the Department. She did not know whether a specified group of assisted living facilities licensed by the DHS were also licensed by the Department.

The court has also considered the testimony of Ms. Diamond and Ms. Donoghue in assessing compliance with these paragraphs.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 254-255 and 257-261 of the Consent Decree.

XV. PLANNING, BUDGETING AND RESOURCE DEVELOPMENT: Paragraphs 262-267

According to the Commissioner, the following have input into the Department's system planning:

1. The Maine Association of Mental Health Services;

2. Quality improvement councils, which include consumers, providers and community leaders;

3. Region III Task Force for Northern Maine. This was created because the focus had been on Southern Maine and it was difficult to get services to highly rural areas;

4. Initiative Group created by Commissioner Duby because of a lack of communication between hospitals and crisis staff;

5. Maine Hospital Association;

6. The courts and judiciary; state agencies, including DOE, DHS, and DOC. With regard to the DOC, Commissioner Duby believed that during the last two years, the Department has had a closer relationship with the DOC. The Department developed a range of services in prisons and release centers and has assigned workers to Probation and Parole. The new prison has a mental health unit;

7. Legislative Committee on Health and Human Services before which the Department must justify its budget and any proposed legislation;

8. The Homeless Coalition, which provides shelters. Commissioner Duby assigned, at some time, a problem-solving group to shelters to try to stop the discharge from the hospitals directly to the homeless shelters;

9. The Maine Association of Substance Abuse Providers. The Department has worked during the last couple of years with the jails and had worked with law enforcement previously. The Department signed a memorandum of understanding with the Penobscot County Jail in April, 2002 and was just about to sign a memorandum of understanding with the Kennebec County Jail at the time of her testimony. The Department was negotiating with the Cumberland County Jail;

10. NAMI-Maine;

11. Consumers and families;

12. Maine Association of Community Services Providers;

13. Co-occurring Collaborative of Southern Maine, which develops training for mental illness and co-occurring substance abuse disorders or addiction;

14. MMDMS, which is a Medicaid information system. The Department collaborates with this system to avoid duplication of data;

15. ORYX. This system was created in order to allow the Department to monitor Maine's psychiatric hospitals;

16. Maine Health Data System;

17. Regional Office of QI Team;

18. Central Office QI Team;

***156** 19. Local service networks;

20. Consumer input.

The budget process for the Department begins in August for the January Legislative session. Information is gathered on a regional level to assess needs and is sent to the central office, where the information is reviewed and supplemented and duplications are removed. Finally, the Governor is presented with the budget. The budget is reviewed again several times depending on the financial situation. Alternative resources for revenue are explored in order to limit the impact of the deficit. At the time of Commissioner Duby's testimony, the Department had submitted its final budget but because of new deficit

numbers, the process had begun again. The Commissioner's testimony that the Department had not proposed reductions that affect class members is not supported by the credible testimony from Mr. Rodman, Mr. Copeland, and Mr. Harden.

The Commissioner was not concerned about the community service providers dependance on Medicaid eligible people to fund the agencies. She stated that if Medicaid did not pay, the general fund would pay. The community service providers would give priority to Medicaid-eligible people only if general funding was gone. She said that she and the agencies had discussed the need for Medicaid-eligible people but she had not heard that they were serving only Medicaid-eligible people. She did not recall whether she had heard that Medicaid-eligible people would be given priority. The court accepts the testimony of Mr. Harden, Mr. Copeland, and Mr. Gardiner on this issue and not Commissioner Duby's testimony.

At the time of the Commissioner's testimony on 10/28/02, a budget bill was pending before the Appropriations Committee. The budget reflected replacement of general fund money with alternative sources. The Governor originally asked the Department to reduce its budget by $11 million; the Department negotiated with the Governor and the figure was reduced to $10 million. At the time of trial, the Department had not been asked to revise its budget since additional budget shortfalls had been uncovered.

According to the Commissioner, the Department's budget had been reduced because it expected additional federal funds from the MaineCare Program. The Department expects an increased number of people to be eligible for MaineCare. *See* Defs.' Ex. 2. She believed that people previously ineligible for MaineCare will qualify by mid-October, 2002. The Department expected to save $1,800,000.00 from 10/2/02 through the end of 2002. This money will be saved only if the assumption that additional people will receive Medicaid is true. This estimate of number of people eligible under the waiver was made based on information from two other unnamed states. The Commissioner did not know the specifics. As discussed below, other providers believe that the Department overestimated the savings and projected a higher number than could be expected to convert to MaineCare. The court accepts Mr. Harden's testimony on this issue and questions the accuracy of the Department's projections.

***157** The Department's plan looked at duplication of services between case management and community support. *See* Jt. Ex. 10, § 17. The Department projected savings of approximately $1,000,000.00 for six months and $2,000,000.00 through the year. Because this involved Medicaid seed money, the Department can expect $6,000,000.00 in savings, $4,000,000.00 in federal dollars and $2,000,000.00 in state dollars. Representatives of the Maine Association of Mental Health Services (MAMHS) testified before the Legislature that MAMHS believed it would have to reduce services. If these savings cannot be realized, Medicaid will pay but will bill the Department. The Department will then have a deficit and will have to request supplemental money from the Legislature, according to Commissioner Duby.

With regard to the supplemental budget prepared for fiscal year 2002, the Commissioner recommended cutting social clubs by 17%. She testified before the Legislature that those cuts would not impact the Consent Decree and agreed at the time of her testimony that that was an oversight on her part.

With regard to the budget process generally, the Commissioner testified that the Department receives information regarding unmet needs for class members. *See* Pls.' Ex. 1. She did not know whether the Department would receive information about a class member's unmet needs if the class member had no ISP. As discussed throughout this order, the information about unmet needs has not been shown to be accurate.

Donald Harden is the Director of Support and Recovery Program at Catholic Charities of Maine, which is the primary provider of community support services in greater Portland. It provides outreach to AMHI, P-6, and a small amount to the jails, and provides services. Catholic Charities has a contract with the Department and is funded by seed money and Medicaid, general fund money, and the United Way. As a member of the MAMHS, he is chairperson of its Legislative Committee and is on the Adult Services Committee and part of the Leadership Committee. He was president of the organization until 10/02.

MAMHS has close communication with the Department and the Commissioner attends its meetings. MAMHS has input in some areas of the mental health services delivery system and in some areas, no input.

MAMHS provided testimony to the Legislature regarding funding curtailments based on concerns about the general fund reductions to core services and concerns that if the Medicaid seed money decreased, the federal match would be lost. MAMHS was also concerned about the reduction planned for funding of social clubs. The clubs are very important to consumers and the proposed reduction in funding was extensive. The social clubs depend entirely on general fund money for funding. The reductions were proposed by the Department; the Legislature ultimately did not agree with those proposed reductions.

The change in Medicaid regulations last year affected funding. There was a non-categorical waiver change,

which did not affect the programs directly. The change opened access to Medicaid based on qualifying at 100% of the poverty level. The assumption was that agencies like Catholic Charities would be newly eligible under the Medicaid waiver so they would not need as much general fund money. The Department projected the percentage increase of those who would be eligible under the waiver who were previously not eligible. The Association's projection differed from that of the Department and the Association explained that fact to the Legislature. MAMHS's research and experience showed that new Medicaid revenue would not come in as projected.

***158** He was not asked to submit a projection of what the change in Medicaid policy would do to people served by his agency He was told that the agency will receive a 10% reduction in general fund money and the agency had to determine how it would absorb that reduction. He was never told to absorb it administratively. The curtailment for Catholic Charities during the fall, 2001 was $72,000.00. The agency previously received $789,000.00 in state grant money plus $1,100,000 .00 in Medicaid seed and $3,300,000.00 in Medicaid.

The change in the wait list acceptance policy for case management provides that non-Medicaid people can not be on the waiting list unless they are class members. Although that could change, Mr. Harden stated that we "are in the year we are in" and the circumstances for fiscal years '04 and '05 are, of course, unknown.

One objective of the rewriting of Section 17 of the Medicaid rules was to avoid duplication in the system. At the time of Mr. Harden's testimony, the rule was being finalized and would be scheduled for public hearing. MAMHS wanted to ensure that agencies can continue to bill for current services under the rewritten rule 17. Community support services provided in AMHI, BMHI, Spring Harbor, Acadia, or jails are non-billable to Medicaid pursuant to federal law.

The percentage of clients Mr. Hardens' agency served in 2002 who were Medicaid-eligible was 80%. That figure is shifting because the amount of general fund dollars to pay for the non-Medicaid people has decreased. The most recent figures showed 87% were Medicaid-eligible and 13% were non-Medicaid. Catholic Charities terminated approximately thirty people because of the reduction in general fund money. Those terminated had no Medicaid. The agency will give notice to anyone who will lose services. The agency does not decide who no longer needs the service and those terminated are not people who no longer need services. The agency talked to the people losing their CSWs and talked to them about their capacity to be on their own. Mr. Harden clearly tried to put the loss of services in the best light to the people losing their services.

The agency's contract with the Department requires it to conduct consumer satisfaction surveys. Mr. Harden sends a survey every month to a random sample and reports quarterly. The agency created its own survey form. The Department did not provide any form as part of the contract. He understood that a form was forthcoming but at the time of his testimony, there was no uniform satisfaction survey for all providers. An assessment process is required by licensing. He understood that a uniform assessment tool will be forthcoming as well but no form had yet been provided by the Department. He had not been told when the agency will receive the assessment tool or the consumer satisfaction survey form.

In the past, Mr. Harden thought he had a strong focus on recovery or "becoming," which means that a client is fully participating in community life, living where he wants to live, being connected socially, having a vision for life and taking steps towards that vision, and moving away from a world where he depends on the mental health system for daily life. In the last few years, Mr. Harden's focus has had to be, instead, on productivity and billable hours.

***159** Christopher Copeland is the Program Director at Tri-County, which provides comprehensive mental health services at four out-patient sites and eighteen other sites. It provides psychiatric, therapy, staff, crisis works, respite program for MR and crisis coverage in Androscoggin, Franklin, Oxford, and northern Cumberland County.

He deals with program issues and provides leadership to managers. Tri-County tries to integrate services as much as possible for efficient operation. He works closely with the fiscal director regarding budget and how to manage programs within their budget.

Tri-County is 75% or 80% Medicaid funded. In a $19,000,000.00 or $20,000,000.00 budget, $3,500,000.00 or $4,000,000.00 is grant money. Tri-County receives some Medicare funds, a small amount of insurance, and a small amount of United Way funds. Tri-County has psychiatric services, out-patient programs for psychotherapy counseling; community supports; one ACT Team; crisis services, which are twenty-four/seven in Androscoggin and northern Cumberland and shared with another agency for Oxford and Franklin; substance abuse services at four residential facilities and apartments; housing services; geriatric outreach for people who are leaving a nursing home and going to their own home; and services for MR.

Tri-County aims to review all ISPs every 90 days and give feedback to the managers. There is no process to ask clients independently about their needs and to match that answer to the ISP. Only the agency documents the agency are reviewed.

During 2002, Tri-County received a 10% budget cut to its

adult contracts. That limits its ability to help people who do not have Medicaid and will affect the ACT Team, crisis, and community supports. At the time of his testimony, the effects of that cut were beginning to be felt in, for example, the ability to staff crisis services and people were waiting for services in emergency rooms at various hospitals. Tri-County was able to provide five crisis workers but that left four or five people waiting. The ability to bring in relief staff is also affected by the budget cuts, which will result in an increase the length of stay for a person in crisis in the emergency room and will affect the ability of staff to see people in crisis in other places as well. Tri-County intends to present to St. Mary's a triage plan for situations in which the number of people in emergency rooms exceeds the staff to deal with those persons.

Tri-County has a waiting list for out-patient services. Services are provided by a licensed clinician and includes individual and group therapy and include psychiatric and psychological counseling. With regard to the wait list for psychiatric services, for example, in Lewiston, the demand far exceeds the ability to give psychiatric services. At the time of his testimony, there was a 200 person wait list out of the Lewiston office; during the previous year, the wait list was 400. They have made efforts to reduce the wait list by increasing the number of out-patient clinicians by three. He did not believe that class members were on the waiting list for services.

***160** When Tri-County receives a call requesting services, it takes details of demographics and present issues. The person is referred to the program that the person needs. If the person meets eligibility requirements, he may be seen immediately or may be put on the wait list. For example, an urgent needs person would be referred to crisis or short-term services. Those who do not go to a particular program would be placed on the out-patient waiting list. A class member is likely to be prioritized on the out-patient services although it is unlikely that a class member would go on that list because, in general, class members have a case manager.

In 10/02, Tri-County was approached by the Department to review the wait time for services. At that time, there was no instructions from the Department regarding maintaining or developing a wait list. A meeting regarding getting services to eligible people was attended by a group from the Department, Dr. Fine, who is the Medical Director for Region II, and others. Prior to that meeting, there were regular contract meetings but no meetings specifically focused on one item. This was the first meeting that focused on the wait list.

The 10/02 meeting resulted in a plan to contact those who have been waiting for services for more than 180 days. There will be a change in the allocation of grant funding from programs to help with the waiting list. The details of that change were to be discussed the week after the date of his testimony. Mr. Copeland did not believe that they would be able to find savings in the programs.

Tri-County has four residential programs, Sabattus, Lewiston, Rumford, and Lisbon. There is no housing in Franklin County. Tri-County does not keep a wait list because there is no dynamic turnover. Further, a wait list would suggest that there is a priority and Tri-County wants to provide services for the most appropriate people. Tri-County accepts referrals and screens for the most suitable clients. Tri-County also has an arrangement with AMHI for discharges to be referred to those residential programs but the demand exceeds the capacity.

Tri-County manages adult crisis stabilization beds. Tri-County would like to increase the number of crisis beds to provide a broader range of crisis services beds, which would allow them to prevent hospitalization or reduce the time in the hospital. There are limits on the acuity levels Tri-County is able to accept. Tri-County wants to add appropriate staff to accept people with more acute problems. Tri-County has to prioritize what it will do and what it can not do, as any business does. Crisis beds are not a priority at this time. Mr. Copeland has had no discussions with the Department regarding this issue.

Tri-County has one ACT Team in Androscoggin County and would like to have another and possibly serve a different population. The ACT Team includes a psychiatrist, a LCSW, a nurse, and four case managers. People with different diagnosis do better with different models. The Department is involved in developing a second ACT Team. Although no grant money is available, Medicaid could be billed. Infrastructures, however, are needed to expand services even if those services will ultimately be paid for by Medicaid. Mr. Copeland stated several times that Tri-County is a business; this complex issue would take time and planning and staff. Hiring experienced staff in certain areas in Maine is very difficult. There also would be start up costs in expanding services, including renting buildings and recruiting people and the Medicaid money would be slow to develop.

***161** Grant money allows Tri-County to serve people who do not have Medicaid. The grant money cuts affected adult mental health community supports, medication management, the ACT Team, and out-patient services. The effect of the cuts on the ACT Team have not yet been felt. Tri-County is concerned about the effect of the cuts on medication management because that program operates with a deficit. The cut in grant money decreases surpluses that in the past had been used to help programs which run with a deficit. Tri-County provides medication management to many people purely on the basis of need; the people served may not have Medicaid. Programs that serve on the basis of need and not on the basis of a payment source certainly run the risk of a incurring a

deficit.

A couple of years ago, Tri-County decided it had to focus more on people who had Medicaid. Tri-County has to match the amount of grant money it has with the number of people served who do not have Medicaid in order to have a balanced budget. The Department has not asked them to track those people turned away because they have no Medicaid. Tri-County has not, however, seen a significant increase in the number of people on Medicaid as a result of that effort to decrease the eligibility level.

Holly Stover is a Regional Director for Region II, which includes the nine middle counties of Maine. She has worked for the Department for five years. Her duties include leadership and oversight for adult mental health and mental retardation on the community side, which includes the ICMs and the contract services with community agencies. She has a staff of 176.

Adult mental health is managed by the mental health team leader; this position for Region II has been a vacant position since November, 2002. There are four CDCs, four supervisors for the ICM program, 31 ICM and peer specialists, and one manager for the in-home support program. She has an assistant regional director, a finance director, team leaders, QI coordinators, a medical director, a UR nurse, and a regional housing coordinator. This arrangement in Region II is comparable to that in Regions I and III.

Ms. Stover testified about the budget process at the regional level. That process involves planning for two years at the beginning of the biennium. Budget forms are sent to agencies. The fiscal experience of the agency is considered, which generally includes MaineCare, State grant finds, and wrap-around funds. Unmet needs/ISP data are entered into the CMA and costs are applied to those needs. Specific requests from providers are also addressed.

The purpose of the part I budget is to maintain the agency's effort based on history; utilization of what the agency has been provided is taken into consideration. The part II budget provides for new or expanded needs, including addressing unmet needs and waiting lists.

The agency data is considered in units of service, which means the number of caseworkers multiplied by the contacts per month multiplied by twelve. The proposed budget is then reviewed by the QICs and the local service networks (LSNs) regarding regional priorities. The regional request represents the budgets from all agencies. The Commissioner submits the Department's budget and then determines regional allocation.

***162** Defendants' exhibit 90A shows the services for which the Department contracts in Kennebec and Somerset Counties and the clients served by payment source. These figures are included in the part I budget in order to maintain the current effort. Paragraph 3(a) shows the cost to serve the uninsured or the underinsured. Ms. Stover termed this an unmet need but still a priority population for the Department; this represents a waiting list because these people are not covered. These figures represent new dollars to be asked for in the part II budget to expand services.

Defendants' exhibit 90B was provided by Sweetser in July, 2000. These figures represent costs to serve people who do not currently receive services; this is the cost to absorb the waiting list and to serve everyone waiting for services. There were 3850 clients on the waiting list and 1750 had no insurance. *See* Defs.' Ex. 90B. This total cost is included in the part II budget.

Defendants' exhibit 90A(b)(2) shows private insurance consumers; she does not know of anyone who has ever paid cash. With regard to the 144 consumers who have no insurance, she also did not know of anyone who would qualify under the new eligibility requirements for Medicaid. *See* Defs.' Ex. 90A(3). The cost for consumers who have no insurance is included in the budget but Region II never has received its entire request.

Ms. Stover receives a copy of the final Department budget prepared by the Commissioner. She was unaware of the percentage of her request budget that was appropriated during the last biennium. She received all of the Medicaid seed request but she did not get all of the requests for uncompensated services. *See* Defs.' Ex. 90A. She did not know what was included for these uncompensated services in the Commissioner's budget or the Governor's budget. She had no idea where the shortfall came from. *See also* Discussion of budget for Tri-County waiting list.

Wrap-around funds provide flexible funding for needs when no other funding exists. The Department has its own wrap-around account and allocates wrap-around funds to agencies, which access the funds directly. The typical use of wrap-around funds does not exceed $500 and addresses a one-time need.

Defendants' exhibit 90D shows the Region II expenditure by agency of the WRAP account for calendar year 2001. *See* Defs.' Ex. 90D, pp. 1-2. This account is monitored at least monthly. WRAP expenditures are a line item in the regional budget.

She did not review survey data. She receives information about unmet needs for those who may not have data in the CMA; not all class members have ISPs in the CMA. ¶ 74. She "expects" that the information will come forward in the budget process and would be included in the wait list data. *See* Defs.' Ex. 90B. On redirect examination, she was shown defendants' exhibits 46A-C. She did not

remember the paragraph of the Consent Decree that these exhibits related to. She stated that she receives and reviews the reports. She testified that defendants' exhibit 46A, page 2 showed the data used to create part one of the budget. She then changed that answer and stated that was the wait list data. *See* Defs.' Ex. 46A, p. 2. Although she testified that this data was always included as a request for additional funds for unmet needs, she did not know the amounts requested, whether the request ultimately were included in the Commissioner's budget, or whether she received any amount of the funds she requested and if so, the amount received.

***163** Ms. Stover clearly had little idea how to respond to questions about budget information. She did not know what she was told by the QIC regarding needs for the last budget. She would have based budget requests on providers' requests for more money. She did not know if that information would be found in the minutes.

Brenda Harvey is the Director of the Office of Program Development at the Department. *See* Defs.' Ex. 1, pp. 19-38. She has a B.A. in social work and a Masters in rehabilitation counseling. She previously served as the Director of Community Systems Development for the Department, Manager and Program Coordinator for a department at Maine Medical Center, Mental Health Program Coordinator for the Department of Mental Health and Mental Retardation, and a vocational rehabilitation counselor at DHS. She reports to the Deputy Commissioner, Sabra Burdick. There are 28 people in her office. She is a member of the Executive Management Team (EMT).

The Office does research with regard to behavioral health. The employees scout research opportunities and collaborate with foundations in Maine to support projects in behavioral health. They seek out promising approaches, best practices, new research in the field of behavioral health, bring the information to the Department, and incorporate the information into strategies for new ways to do what they do. The Office also does planning and development training for employees of the Department and develop training plans for the field. The community system development has five topic areas: deaf and multi-cultural, employment support, housing, elder persons, and trauma.

The Office determines the efficacy of practices for delivery of services. Her staff has relationships with national organizations. They look for evidence-based practices to use in Maine programs. For example, SAMSA is a federal project to which the Office has applied to fund evidence-based practices in Maine. They will hear in May, 2002 whether the Office received the grant. According to Ms. Harvey, evidence-based practice is already integrated in employment support and the trauma program. There is a multi-state effort to develop evidence-based practices with Maine Medical Center and to incorporate the practices in Maine. There is a pilot project with Tri-County. Dr. Yoe has an infrastructure grant to look at findings of evidence-based practices in all states.

Ms. Harvey supervises Dr. Yoe. QI is now a nine-person undertaking. She facilitates discussions at the executive management level regarding the need for QI. She participates in the process improvement planning and procedure. When the QI plan was upgraded, she took a leadership role and provided training and facilitation. She was a liaison to the Commissioner and relayed the Commissioner's comments to the QI staff and into the QI packets. The Commissioner suggested improvements for the "untrained reader" and to focus attention by the QI staff.

***164** The EMT meets weekly. It looks at the quarterly reports from the program teams. The EMT does not look at the results of the ISP document reviews with regard to information on unmet needs and goals. *See* Jt. Ex. 22, p. 73818. Data are reviewed by the mental health team. The EMT discusses and suggests improvements. She looked at the twelve QI reports and recommendations to determine which recommendations should be incorporated into the tracking system and which were unreasonable. Her briefing memo is dated 8/29/02. *See* Defs.' Ex. 65; *see also* Defs.' Exs. 63, 64. The tracking report has a run date of 10/21/02 and involves recommendations made after 1/25/02. *See* Defs.' Ex. 67.

Her office does not conduct public forums. The Office of Consumer Affairs works with groups of consumers.

She applies for grants, which totaled $7,000,000.00 by 1/25/02. The Office decides to apply for grants based on information from the mental health teams and after discussion at the EMT. She said that the Department is relatively new at these tasks. The research initiative is a new effort; the Department had no research office previously.

She was asked whether the QI process had generated specific rounds of data in order for her to decide which areas need further examination. The Office obtained data when the synopsis was done, which was after 1/25/02.

Karen Evans is employed by the DRC on a part-time basis. She has been a member of three QI councils: the AMHI QI Counsel for two or three years, the state-wide QI Counsel for four or five years, and the Cumberland QI Counsel for six months. There was no vote to dissolve the Cumberland QIC but it was disbanded one and one-half or two years prior to her testimony.

At the AMHI QIC meetings, the Superintendent provided a report and the members received a financial report.

There were three committees in this QIC: projects; surveys, discharge planning/QA; and transition to the new psychiatric center. There is also a Fun Committee, which was instituted two years ago to arrange entertainment for the people at AMHI. AMHI co-sponsors these activities. The budget for this committee was cut in half to $5,000 for fiscal year 2003.

Prior to 1/25/02, there was no presentation to the AMHI QIC on QI process, the AMHI budget, or the survey or the results of the hospital class member interview at meetings. *See* Jt. Ex. 22, p. 73720. With regard to the statewide committee, she had never seen the survey or the results of the community class member interview prior to 1/25/02. *See* Jt. Ex. 22, p. 73707.

About a year before Ms. Evans's testimony, Dr.Yoe discussed with the statewide QIC the data infrastructure grant. No data were presented. In May or June, 2002, someone from housing made a presentation regarding a draft report. Although she asked for a copy of the report three times, she received it only after making a request pursuant to the Freedom of Information Act. A vote was taken at the Cumberland QIC to obtain critical incident information but the information was not received. Ms. Evans requested the information pursuant to the Freedom of Information Act and received basically numbers, not confidential information.

***165** The inability of the defendants to identify and meet class members' needs affects the ability to comply with paragraphs 262, 263, and 264, all of which specifically address identifying and meeting those needs. Paragraph 265 requires development of resources to maximize clients' strengths and independence and designed to integrate clients fully into the mainstream of community life. The goal of meeting class members' needs must drive planning, budgeting, and resource development. The testimony of the class member and their relatives and Mr. Rodman, in particular, is considered in determining compliance with these paragraphs.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 262-265 of the Consent Decree.

XVI. MISCELLANEOUS: Paragraphs 268-273

Budgets
The defendants are required to prepare budget requests that are calculated to meet the terms of the Consent Decree and to "take all necessary steps and exert good faith efforts" to obtain adequate funding from the Legislature. On 2/10/03, before his testimony, Mr. Rodman was handed a summary of the Governor's budget for the Department. Substantial cuts totaling two and one-half million dollars for the biennium are proposed in the adult mental health services' budget. Vocational services will be eliminated and there will be cuts in the substance abuse services. The budget also contains a section regarding the Consent Decree, which provides that rules will be developed to restrict the duration and frequency of unspecified services. There is specific reference to increasing room and board fees in residential treatment facilities. There is also discussion of curtailment of services to non-Medicaid eligible patients. *See also* Sections XV, above.

Mr. Rodman had not received any documents regarding the defendants' planning for cuts in the budget. He did not consider receipt of the summary as compliance with paragraph 268. He did not consider the summary a budget and, further, he had no budget information for the DHS. The Department has not approached Mr. Rodman regarding the Section 17 Medicaid changes and he has seen no submissions regarding the changes.

The testimony in section VX about budgeting is considered in determining compliance with paragraph 268, which requires the defendants to prepare budget requests to meet the terms of the Consent Decree.

Capacity
Dr. Nelson testified regarding paragraphs 269-271.

Defendants' Designees
This paragraph requires the defendants to ensure that any delegated tasks have been completed.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 268-272 of the Consent Decree.

XVII. QUALITY ASSURANCE, INTERNAL MONITORING, REPORTING AND IMPLEMENTATION: Paragraphs 274-283

Licensing
Louis Dorogi is the Director of the Division of Licensing and Certification at the Bureau of Medical Services and the DHS. He reviews hospitals for licensure compliance and for medicare and medicaid compliance. *See* Jt. Ex. 4 (survey tools).

***166** Psychiatric hospitals have to meet two special conditions regarding medical records and staffing. These federal standards and the federal standards for patient rights are incorporated into state licensure regulations. *See*

Defs.' Exs. 80A (hospital interpretive guidelines on patient rights) & 80B (interpretive guidelines for psychiatric hospitals, which specifies medical staffing and medical records).

He reviews the non-state facilities, Acadia and Spring Harbor. He may be asked to perform reviews of state facilities for the federal agency, CMS, as a result of a complaint investigation. He also performs validation surveys of psychiatric hospitals for the federal agency.

He also surveys hospitals under state licensing procedures every three years. *See* Jt. Ex. 4, p. 71611. It is apparently these state standards that are relied on by Superintendent Kavanaugh to determine compliance with the Consent Decree. *See e.g.,* ¶¶ 83, 157, 160-168, 180-191, 202-204, 250-25, 282-283. Patient records are reviewed and patients and staff are interviewed. *See, e.g.,* Jt. Ex. 4, pp. 149-50 (treatment planning); p. 142 (treatment plan); p. 156 (written active plan). The plan must be completed within fourteen days of admission and must be reviewed within 60 days. *See* Jt. Ex. 4, p. 150. If there are deficiencies, a statement of deficiencies issues. A detailed plan of correction is required within ten days.

State licenses are issued for a one-year period based on a review of the record of the facility. A conditional license contains conditions that have to be met within a certain time period and the facility is monitored throughout the twelve-month period. A full license means that a facility is in substantial compliance, which means there is evidence that the facility is meeting licensing regulations and that there are no major systems breakdowns. A full license does not mean that there are no deficiencies.

The last survey of AMHI was done 6/14/01, which involved a review of all of AMHI's documentation and a three-day on-site visit. AMHI received approximately four to six weeks notice of this licensing procedure. During the 6/01 licensing procedure, deficiencies were noted. AMHI made changes to correct the deficiencies. *See* Jt. Ex. 13 (license). A current full license is in effect for the period 11/1/02 through 10/31/03. From 1989 through 1993 and 1996 to 1998, AMHI had a conditional license. At the time of his testimony, BMHI was operating under a conditional license.

Since 11/01, the DHS had returned to AMHI nine times. Any complaint to the DHS requires an unannounced visit by DHS. Also, AMHI must report any allegation or complaint.

AMHI was last surveyed in 1/01 by the JCAHO. *See* Defs.' Ex. 6. AMHI received a score of 89. AMHI submitted a written progress report subsequent to that scoring. AMHI's score now is 94. As noted, this scoring method was not well explained by any witness with knowledge of the issue.

***167** The Department has a role in licensing review. A representative of the Department is expected to accompany the licensure survey team to review the RRMHS under chapters 23 & 25. *See* Jt. Ex. 4; Defs.' Ex. 80C. If the federal standards differ from the state standard, the more restrictive regulation is used. If a violation of the regulations is found, the survey team meets and the team determines how to include the finding in the statement of deficiency. The final decision is made by a DHS employee with input from the Department. The Department staff involved in licensing survey process uses its own form for RRMHS, which is not included in joint exhibit 4.

Mr. Dorogi had not compared the Consent Decree requirements with licensure requirements. He was unable to comment on whether AMHI would comply with the Consent Decree requirements if AMHI met the licensure requirements.

When doing reviews of community hospitals, the licensure division checks blue papers to ensure that admissions comply with state law. *See* Jt. Ex. 4, Ch. 6. There was no reference, however, to title 34-B, which is the state standard.

Mr. Dorogi reports to the Court Master and includes survey information and information specifically with regard to psychiatric hospital units and complaints. At the time of his testimony, he had a pending complaint involving a community hospital.

B. Contracts

Ms. Stover approves contracts with provider agencies. For the current year, Region II has 44 agencies and 44 contracts, including four hospital contracts, in the adult mental health area. Each agency has one contract regardless of the number of services provided. She meets with each agency at least two or three times per year. She attends fewer than ten meeting per year. She agreed that her testimony was based on what other employees tell her.

Two years before her testimony, Region II had approximately 39 contracts. Contracts for new services were added to Region II during the last year. These contracts are annualized except for the St. Joseph's Nursing Care Facility, which is done every five years, and the hospitals, which are done every two years. The total value of these Region II contracts is $55,000,000.00, which includes $14,000,000.00 in state money, seed money matched with federal dollars, and a $1,000,000.00 mental health block grant, which is federal money.

The Bancroft facility had a contract with Region II for at least six years. The contract was not renewed at the end of

fiscal year 2002. She did not meet with anyone from Bancroft during 2002. She did not know whether other Department employees met with Bancroft personnel. The problems there were not discussed by her with anyone. Problems were discussed during the licensing review in the late winter of 2002.

Region II contracts for transportation. There is a compelling need for transportation across Region II. The agencies provide vouchers and reimburse family members who provide transportation. The CSWs provide transportation. The agencies use wrap-around funds for transportation and for purchase of automobiles and repair.

***168** Tri-County provides community support, including an ACT Team, out-patient services, housing, crisis, and medication clinics. *See* Defs.' Ex. 56C (2001-2002 and 2002-2003 contracts with Tri-County), Rider A (services). The contract requires that providers will work cooperatively with the Department in fulfilling its requirements under the Consent Decree. *See* Defs.' Ex. 56C, Rider D, p. 1 (2001-2002); *see* Rider E (2002-2003); *see also* Defs.' Ex. 91 (annotated for Consent Decree; in effect before 1/1/02). The Department has similar contracts with 40 agencies. *See also* Defs.' Exs. 56B (Mid-Coast contract); 56A (Motivational Services contract). All of the contracts have essentially the same boilerplate language as appears in the Tri-County contract.

The Department has an emergency involuntary admissions contract with Maine General. *See* Defs.' Ex. 49; *see also* Defs.' Ex. 92 (annotated for Consent Decree; in effect before 1/1/02). Ms. Stover reviews and signs the other hospital contracts and believes all hospital contracts look the same. The UR requirement is consistent for all hospitals. *See* Defs.' Ex. 49, Rider A, p. 6; *see also id.,* Rider A, pp. 11-12 (in all hospital contracts).

Ms. Stover prepared defendants' exhibits 91 and 92, agency and hospital contracts that are annotated to the Consent Decree, between 11/14/02 and 12/9/02. She had never done that sort of review previously with regard to the Consent Decree paragraphs. She has no input into the standard, boilerplate language included in all Department contracts.

She does not have uniform intake and assessment tools from the Department, as specified in the program requirements. *See* Defs.' Ex. 91, p. 1, ¶ 3. She said that Region II monitors progress on ISPs with the CDCs to determine whether providers are abiding by and implementing the ISP policies, procedures, practices, and protocols established by the Department. *See id.,* ¶ 4. After several inquiries, she finally agreed that she does not participate in any monitoring of agencies' cooperation. For example, she is not involved in monitoring compliance with an ISP when a consumer receives services from more than one agency. The CDCs have quarterly meetings to address these issues.

She agreed that the language in the provider agency contract regarding service standards is not a smooth fit with paragraph 69. *See* Defs.' Ex. 91, p. 2, ¶ 5. She did not know why the term "general public" was used because the services are not available to the general public; eligibility requirements must be met. She monitors whether people were refused services because of substance abuse issues by talking with providers and by giving to clients the notice of rights to compliance with the Consent Decree at intake and at any other time that they ask for it. *See* Defs.' Ex. 91, p. 2 (dual diagnosis).

Face-to-face contact from 8:00 a.m. to 8:00 p.m. is the "expectation." ICMs are available during those hours. She is unaware whether the clients know that services are available during those hours and has done nothing to gather that information.

***169** Contrary to the program requirements language, Ms. Stover agreed that there is no language in the Consent Decree that says that a CSW or liaison worker can have contact with the client by telephone if the worker cannot attend treatment or discharge planning meetings in person. *See* Defs.' Ex. 91, p. 7, ¶ d. Paragraph 55 provides that "the community support worker shall be responsible for participating at hospital treatment and discharge planning meetings...." She relies on the agency and hospital reports to monitor a case manager's contact with the client. She has no data from the agencies and the data from the hospital are not accurate. Other than encouraging case managers to participate, she has done nothing to monitor compliance with this requirement.

Ms. Stover stated that it is an "expectation" that there will be compliance with the requirement that the CSW will execute a written service agreement when services will be delivered by a state licensed or funded agency. *See* Defs.' Ex. 91, p. 8, ¶ j. She expects the Consent Decree office to monitor this requirement and to give feedback regarding deficiencies. If, however, a client gets CSW services from, for example, Motivational Services, and also gets psychiatric services from Motivational Services, there is no written service agreement required. She agreed that there is no language that excludes that scenario from the written service agreement requirement but the Department does not require a written agreement. *See id.* A service agreement is not required from a DHS-licensed agency. *See* Jt. Ex. 25, p. 67993.

She was unable to think of a reference in the program requirements rider for the provisions of paragraph 32(h) regarding a class member's refusal of all or some services offered. *See* Defs .' Ex. 91. She does not monitor any of the requirements of paragraph 32(a)-(h). *See* Defs.' Ex. 91 (no cite to ¶ 32). Once again, it is an "expectation"

through contracts and licensing. Efforts during redirect examination to rehabilitate this witness in terms of knowledge of the Consent Decree failed. In response to a leading question, she could state only that she "believed" that the contract required providing the RRMHS and that paragraph 32 is included in the rights. *See* Jt. Ex. 8, p. 9.

She did not know whether there were boarding homes in Region II that had more than 40 clients or more than 20 clients. She does nothing to assure that individuals living in boarding homes with more than eight people were advised of the availability of smaller homes. She stated that she had not been instructed to monitor that requirement.

She alleged that Region II provides services to non-class members and those people are not excluded or refused. *See* Paragraph 32(g). She agreed, however, that there are differences in the numbers in wait list data between class members and non-class members. When was asked whether she had done anything to insure that the difference in the wait list numbers was not due to a person's status as a class member or non-class member, she responded that she puts numbers in the budget. Asked again what she does to assure that the difference in numbers is not because someone is not a class member, she responded that she builds money into the budget. She then stated that she did not have an answer to the question.

***170** Except for paragraph 89, paragraphs 88-92, the hospitalization paragraphs, are not cited in the rider for hospital contracts. *See* Defs.' Ex. 92, p. 4. Ms. Stover was asked where the requirements of paragraph 90 appear in defendants' exhibit 92 and she referenced page 2, II(A)(1) and (2) and page 3. As noted above, it became increasingly clear throughout her testimony that Ms. Stover had little familiarity with the requirements of the Consent Decree. She was able to recall on redirect examination that the UR component reviews terms of the hospital contracts. *See* Defs.' Ex. 91, p. 7. The UR nurse reviews, however, hospital contracts and charts with regard to involuntary patients. Accordingly, the requirement that a CSW participate in plans would not be reviewed by the UR nurse.

The Assurance Statement of the hospital contracts provides that training for employees regarding perspectives and values of consumers will be provided "in part" by consumers. *See* Defs.' Ex. 92, p. 5, ¶ 11(h). That language is a modification of the Consent Decree language. *See* Paragraph 121. She has no mechanism to monitor this requirement. Asked on redirect examination whether she knew if licensing had requirements regarding training by clients, she said she could not cite to anything but she "expects so."

Evaluation of performance objectives in hospital contracts (called performance indicators in agency contracts) is expected to be done through the UR process. The procedure provides that the UR nurse visits the community hospital, has patient contact, reviews patient charts for specific items relating to the patient care, and reports to the region. Additionally, the hospital is required to participate and report on programs and financial activities.

Contract review occurs bi-annually but the Department hopes to do this review at least three times per year for agencies. The Department reviews the quarterly reports, which are tied to payment. The review is done by the mental health team, coordinator, the finance director, management analyst, who is a contract manager, the QI coordinator for the Region, and potentially the housing coordinator, the assistant regional director, and the regional director.

C. Quality Assurance and Internal Monitoring

The evidence presented on the important requirement that the defendants "design a comprehensive system of internal monitoring, evaluation and quality assurance for all areas" of the Consent Decree is discussed in this order. ¶ 279. But the fundamental reason for the defendants' inability to comply with these requirements can be summarized by the testimony of two of the defendants' witnesses. Ms. Mulhearn developed a personal mark for hospitalization rates after crisis because the Department has provided no benchmarks for any of the areas she reports on. Ms. Goodwin-Alley's agency uses its "own indicators" to determine whether a number "seems high or low" in the areas it reports on because the Department has provided no benchmarks.

***171** Michelle Briggs was, at the time of her testimony, the Performance Improvement Director at AMHI and had held that job for four years. Her job was terminated at some point after her testimony. She had been employed at AMHI for six years. Her responsibilities were to ensure that the continuous performance improvement process (CPI) was effective. Previously, she was a clinical dietician and dietary service manager at AMHI. She was on the AEC and helped to write the quality compliance report.

Ms. Briggs described QI at AMHI. The DHS and JCAHO require QI to be in place. AMHI has moved from a QA to a QI model. The QI focus at AMHI is on the use of functional teams. In theory, QI studies processes to see if they are effective and to make them more timely; QA is a method to monitor processes only. *See* Defs.' Ex. 34 (CPI plan for previous fiscal year); Defs.' Ex. 35 (CPI plan pending approval for current year; Ms. Briggs's discussion of defendants' exhibit 35 is omitted).

According to Ms. Briggs, the functional teams report on areas they monitor and determine and track what is required by the Consent Decree and JCAHO. This testimony is simply not supported by the evidence. She continued to describe the process. If there is a concern in an area, the team develops a new indicator. If a new team is requested, the team develops indicators and reports to senior management; the request is made to the AEC but leadership must agree. AMHI focuses on high risk, high cost, and high frequency areas.

The functional team handbook explains the functional team approach and mirrors what is in the QI plan. *See* Defs.' Ex. 40. The handbook will be updated during 2002.

Packets are given to the risk management committee, which collects data, identifies trends, and tracks indicators by unit. *See* Defs.' Ex. 36. JCAHO requires that AMHI perform a review of charts. *See* Defs.' Ex. 37. This process was developed in order to review the charts and demonstrate compliance and break down for the requirements of JCAHO, DHS, and the Consent Decree. This review is for open charts so that improvements can be made before the charts are closed. Originally, AMHI reviewed twelve charts a month but this was very time consuming because it took an hour per chart and AMHI fell behind in completing this task. AMHI then assigned this task to a later duty nurse and AMHI became current through 04/02. Another nurse then did the review for April through August, 2002.

There was, however, a difference in interpretation between the work of these two nurses regarding the rate of compliance. The current process to rectify that problem has been in effect since 9/02 and the task has been given back to the Program Service Directors and other staff. This testimony is consistent with other evidence, which supports the conclusion that AMHI did not, as of 1/25/02, have a process to monitor compliance with the Consent Decree.

A worksheet for clinical pertinence has been used since 1997 to ensure that the JCAHO, as opposed to Consent Decree, requirements are part of the chart. *See* Defs.' Ex. 38. These are reviewed by the medical records committee and the findings are sent to the Medical Director, the heads of the departments that could be affected by the issues, and to the AEC on a quarterly basis.

***172** AMHI uses patient satisfaction surveys developed in 1999. The survey had seventeen questions and was used until 02/01, when AMHI realized that it needed to breakdown or reword the survey. From 3/01 until 12/01 AMHI used a 26 question survey. The NASMHPD survey is now used. The court considers as very significant Ms. Briggs's admission that this new survey was not designed to track the Consent Decree requirements. That survey is designed to track data throughout the country. Ms. Briggs was asked whether paragraph 279 of the Consent Decree had been considered before revamping AMHI's survey. She responded that she did not think that the hospital alone would be responsible for tracking those requirements. The paragraph applies to the defendants but certainly AMHI is responsible for complying with these requirements as they apply to AMHI.

AMHI does not provide individual results by question, just by domain. Accordingly, if a patient said that "my psychiatrist does not listen to me," that would not be shown. According to Ms. Briggs, it is not useful to give data for each question; it is best to "trend by domain." Further, it is not feasible to review every survey. This testimony was not explained and makes no sense.

The functional teams receive only the written comments and results of domains. AMHI was at the time of her testimony without a volunteer to help do the surveys. As of 6/02, AMHI was without a peer support specialist as well. Patients initially were given surveys on admission; that procedure was changed to discharge.

The raw data from the patient satisfaction surveys are compiled. *See* Jt. Ex. 19; Pls.' Ex. 22. AMHI looked at the number of responses and the number of questions answered from 62 surveys. If a question was answered "n/a," it was not included in the results. She agreed that the answer "n/a" to question # 14 should have been included. *See* Pls.' Ex. 22 ("My ideas were included in my treatment plan.").

The use of surveys was described by Ms. Briggs as a "work in progress." An advocate or a volunteer helps the patient fill out the survey at discharge if the patient is willing. She was asked what areas the Consent Decree were required to be monitored through customer surveys. She responded that she did not specifically remember "off the top of [her] head." She had never seen the class member hospital survey. *See* Pls.' Ex. 21; *see also* Pls.' Exs. 23, 24 (long-stay patient surveys); Pls.' Ex. 25 (NASMHPD survey).

With regard to question # 18 on the long-term stay patient surveys, to which 15 out of 44 patients responded either "disagree" or "strongly disagree," Ms. Briggs testified that she would expect that those answers would affect the results for the "domains" so it would affect comparison of AMHI nationally. *See* Pls.' Exs. 23, 24. That question reads, "I feel the recreational activities that are offered meet my needs." The class members at AMHI who testified underlined this problem at AMHI.

***173** Incident reports are to be reviewed by the risk manager. Data are entered and reviewed for timeliness of the report. The incident reports are compiled monthly and reviewed monthly and sent quarterly to the AEC. The review committee looks for "trends."

The utilization management (UM) plan is required and reviewed every year. *See* Jt. Ex. 16 (weekly worksheet for UM department dated 1/23/02). Most of the work is done by the UM nurse and it is reviewed by the AEC and the Medical Executive Committee. The UM plan had been approved during September or October, 2002.

AMHI uses visitor surveys. JCAHO requires surveys to be given to family members. These surveys are available on four units and at the front desk. With the implementation of security officers, these forms will be distributed and Ms. Briggs hoped there would be a greater return. Originally, the feedback was "rather vague" and the surveys were revised 2/02.

The ORYX system provides a method to compare AMHI with other facilities and is a requirement of JCAHO. According to Ms. Briggs, the results are reviewed to compare AMHI with 250 hospitals, depending on the indicator.

The compliance officer position at AMHI was filled March or April, 2002. Monitoring the functional teams to ensure that they met consistently has been a problem.

Although some of the requirements of the Consent Decree were tracked, Ms. Briggs admitted, as did the Superintendent, that AMHI does not monitor for compliance every paragraph that applies to AMHI in the Consent Decree. The decision to monitor is based on high risk, cost, and frequency because, according to Ms. Briggs, there is not enough money to monitor everything. Although she testified that it would be "high cost" to document every paragraph of the Consent Decree, no cost analysis has been done.

AMHI noted trends in the 2001 and 2002 chart reviews but the reliability of that data was questioned because of concerns about the person conducting those reviews. She noted "trends" in the timeliness of the 72-hour review and also documentation of education. She described the data with regard to the patient education as a "concern" but not a trend. She agreed that the 72-hour assessment requirement percentages from March through June, 2002, 27%, 67%, 75%, and 50%, show that this issue was not addressed. *See* Pls.' Ex. 20. She suggested the often-used explanation that the poor percentages for "patient educated" lines is a problem with documentation and not a real problem. That explanation is rejected.

Ms. Briggs testified "I do not remember" when asked whether she was consulted by anyone about her position regarding the ability to document compliance with the Consent Decree. With regard to compliance, she said that indicators are things that are going to be measured and it's important to have them and thresholds or standards. If there is an indicator for a Consent Decree requirement, there would be a threshold. According to Ms. Briggs, indicators for the Consent Decree include the 30-minute medical review after hours; leisure activity, for which she considered 80% to be the threshold; counseling hours, for which she would expect 100% to be a threshold; CSW referrals, for which AMHI had not defined threshold. She believed that the Superintendent expects a compliance rate of 80% or higher, but that expectation is not in writing. She agreed that in many cases it is important to have clearly articulated standards. Ms. Briggs's testimony was not helpful to the defendants.

***174** Mr. Rodman has long been concerned about documentation and management of information at AMHI. *See, e.g.,* Pls.' Ex. 67. His conclusions in this regard are accepted instead of Ms. Briggs's very optimistic description of the process. As of 1/25/02, there clearly was a problem collecting reliable and consistent data at AMHI.

Ms. Harrison chairs the mental health QI team. Quarterly, they receive information regarding QI activities for the previous quarter. They review the information and meet, usually more than once, and conclude with recommendations regarding statewide or regional issues. The QI process affects contract reviews. They identify certain service areas or agencies that they want to do more with and they use information from grievances against an agency.

Ms. Stover receives licensing reports from the licensing department. Those reports are sent to the QI coordinator, the CDCs, the mental team leader for the program side, and to the contract manager and the finance director for the fiscal side.

Region II also has the QI councils, which include providers and community members and may include consumers and family members, the Kennebec/Somerset case management consortium, and the mentor group for support and management of adult mental health services. The Kennebec/Somerset consortium meets twice monthly. Ms. Stover meets quarterly with the Case Management Executive Committee.

The LSNs in Region II include Western, which is Androscoggin, Oxford and Franklin, and Kennebec/Somerset. She attends the west meetings monthly but delegates attendance at the monthly Kennebec/Somerset meetings to the assistant regional director. She meets with the executive directors to discuss case management issues approximately three times per year. The ICM supervisor attends the consortium meeting on a biweekly basis. She attends those meetings three or four times per year. She meets with the Franklin County Criminal Justice Collaboration and the Regional Children's Cabinet. She has inter-departmental meetings with DOC and DHS.

The LSN meetings includes discussion of monthly provision of crisis services, case management, other business and information, and updates and review of the Kennebec/Somerset monthly data sheet with regard to numbers of face-to-face contacts, number of telephone contacts, number of hospitalizations, and number of calls. This review should provide feedback to other providers and an opportunity for crisis to alert other agencies to staff turnover and other issues. Input from consumers comes directly from telephone and mail and indirectly through the grievance process.

Feedback to QICs, LSNs, and the consortiums is given by providers, particularly in the field, and family members. She hears informal concerns about consumers from family members. If these concerns address quality or delivery of services or a person working at an agency, she follows up with what is available and appropriate. She testified that she always follows up with an agency if the concern is legitimate.

***175** The quarterly report documents performance, described as the services provided by the agency and the frequency of provision of the services. *See* Defs.' Ex. 56C, Attachment A; *see also* Defs.' Exs. 68A & 68B. The forms are developed by the central office, the performance indicator team, and Dr. Yoe and given to the Regions to include as a requirement in the contracts.

Ms. Stover had no input on the change in performance indicators for 2003. The QI coordinator had input. She took no action when she learned that the performance indicators had changed regarding collection of information from-clients. The only information from clients now will come indirectly through grievances.

Ms. Stover relies on her staff to review performance indicators and to raise any issues in reports. *See id.* The reports are distributed to the Financial Director and the Assistant Regional Director. The performance indicator forms are forwarded to the QI coordinator and the data are entered into the database. These reports are discussed with the contract team, the finance director, the management analyst, the mental health team leader, the QI coordinator, the CDCs and sometimes the UR Nurse, the assistant regional director and Ms. Stover. The focus is on spending, on whether the agency is not providing a level of care required in the contract because of, for example, excessive vacancies or high staff turnover, and on Medicaid data to determine if Medicaid patients are getting service. They consider overall agency performance since the last reporting period.

Ms. Stover described the process through which the CDCs attend the quarterly meetings regarding ISP quality and timeliness and offer training. The performance indicator numbers are reviewed. If performance is a problem, plans for correction are expected to be made and the numbers reviewed in the next quarterly report. A program review can be conducted if performance is a significant problem. A team analyzes services and provides recommendations for improvements or changes. Discussions at the program reviews can include tracking the waiting list to staff turnovers and vacancies.

Region II recently conducted a program review for Tri-County. The waiting lists at Tri-county had existed for several years. It was reported that there were 500 people on the waiting list for out-patient services and that the number was not decreasing. She was asked whether she gave any instructions to her staff regarding waiting list data; she had "inquired" regarding the number of people waiting for outpatient treatment at Tri-county during the summer of 2002. Tri-county had a high number of consumers on the waiting list for all of fiscal year 2002 but no action was taken until the end of 2002. No report about this issue had been prepared as of November, 2002. Although she testified that the waiting list data for Tri-County was calculated into the budget, the number of consumers on the waiting list continued to increase. She did not remember whether funds were included in the last biennium budget to address the waiting list. Ms. Stover did not know whether the Commissioner included the money that had been requested.

***176** In the critical incidents reports, agencies report on life threatening situations or untimely deaths, and any "newsworthy" event. Hospitals report on emergency, involuntary incidents. If serious harm results from an incident, the agency is expected contact Ms. Stover within four hours. A report is due from the agency within 24 hours. A level 2 situation requires notification within 24 hours and a report within 48 hours. Ms. Stover forwards the reports to the critical incident team and to licensing. That team meets biweekly but will review a report when it is received. The team "plans" so the event will not occur again and will be handled differently. These reports are entered on the database. The critical incidents reports go to the critical incident team, the QI office for data entry, and to the Commissioner.

She reviews summary data on the critical incidents prepared by Dr. Yoe but agreed that it had been some time since she has seen the data. She did not know the percentage of recipients of mental health service who live in Region II. *See* Jt. Ex. 22, p. 73621. Region II has 53% of the critical incidents; Ms. Stover described that figure as "notable," although she said that Region II encourages and asks for critical incident reports and has more providers, counties, people, and contracts than in the Regions I or III. She agreed that she had no reason to think that Region I was not reporting accurately its critical incidents and could not explain the differential except to note that the information on the critical incident report is subjective, is not always completed properly, and

additional information is sometimes required. Some attorneys for agencies have advised them not to include certain information on critical incident reports because of federal confidentiality requirements.

Although Ms. Stover testified on direct examination that agencies "often" take action before the Department becomes involved after a critical incident, she could think of only one time that such action was taken. One agency fired an employee because of an unwanted contact with a client before the Department became involved in the complaint.

The consumer satisfaction surveys are discussed at the quarterly meetings she attends. There was a concern by crisis providers that they were offering surveys to people who did not want services and did not want to do a survey. The crisis providers' concerns would not be a problem with people in residences but the survey from crisis patients and residential patients has been deleted.

Ms. Stover agreed that she would not know if a person not in services wanted services unless the person requested them. Public forums are held and the LSNs and the QI counsel meet. Notice of the meetings is included in the minutes of the QI counsel. She did not know how any individual would know when the next QI counsel meeting would be held.

Meetings of the QICs previously were monthly but now are sporadic. The QIC on the coast has not met for six months. In Kennebec and Somerset, the QIC, which consists of consumers, families, and a small number of providers, and the LSN, which is a group of providers, merged. Although legislation is in effect regarding these organizations, no statutory change was sought to accomplish this merger. In spite of the fact that the consumer organization has now merged with an organization comprised solely of providers, she testified that this merger does "not necessarily limit" input by consumers.

***177** She has discussed face-to-face contacts in the QIC meetings. She does not know the percentage of contacts that should be face-to-face but that the percentage is in the contract. She was unable to find the percentage in the contract. *See* Defs.' Ex. 56B. She stated that years ago, they had an "expectation." She then admitted that she was wrong to testify that there is a benchmark for face-to-face contacts; there is no benchmark. It was discontinued by central office. Her Region had no input in that decision and she has no idea why the decision was made.

Ms. Santeramo described a mentor group for Region I, which consists of mental health team leaders, CDCs, CSWs, a consumer representative, and a representative from the office of consumer affairs. Others are invited depending on the topic to be discussed. This group meets monthly in Region I. The group was originally created to develop ISPs but now works on Consent Decree issues and community support issues; sometimes ISP issues are raised. The group informs agencies regarding efforts to comply with Consent Decree requirements. Region I also has a QI team in the regional office, which includes a CDC, a financial person, an ICM supervisor, and a representative from the office of consumer affairs.

James Yoe is the Director of QI at the Department and has been for five and one-half years. He has a Ph.D in experimental psychology. The QI office has nine staff; three to three and one-half people focus on adult mental health. When he joined the QI office, he was the only employee. The majority of their growth has occurred during the last year, *i.e.,* 2002. The court notes that a significant part of Dr. Yoe's testimony focused on the period after 1/25/02.

His office oversees QI for the entire Department. AMHI and BMHI have their own systems to assess quality because of JCAHO requirements. He advises AMHI and BMHI and talks with them on a monthly basis.

He has multiple functions: (1) develop and maintain QI data collection system; (2) analyze, report, and disseminate data sources; (3) ongoing technical assistance for QI and PI for hospitals; (4) development and implementation of an annual QI plan. Each region has a program team. He does all of this work for adult MR, adult mental health, and children.

According to Dr. Yoe, quality assurance is identification of problems and a method to fix or correct problems that are identified. QI is continuous tracking of quality issues in the system, with a focus on the system and patterns. Before 1/02, the QA mechanisms in place to address clients rights included licensing reviews, the UR process, and the survey process, including class members surveys, ISP consumer surveys, and the grievance process. The UR process involves documentation of information from admissions reviews that the UR nurse conducts regarding rights, admissions, and discharges. The data are entered in the data base and are used directly by his office for QI purposes. The critical incident data are entered, revised for error and omissions, and summarized for review by the QI teams. They developed the original form and process in 1997. Much of this work has been taken over by the Medical Director and QI director for the regions.

***178** QI data for ISPs are sent to his office but the office is not involved in the review. They analyze ISPs for QI purposes and also have ISP consumer surveys two times per year. His office developed the survey and summarizes the data for review by the QI teams. The office also receives ISP goal tracking and community support provider survey data for data entry and analysis. The office also receive the CDCs' waiting list summary one

time per month for QI review process and the unmet needs data from ISPs.

The ISP goal tracking was instituted January, 2001. The data, including the date the goal was initiated, how it was resolved, and the outcome of the goal, are entered in the central system. His office examines trends from that data to determine how long a goal was open and how the goals were completed. Goals tracking data are analyzed quarterly, summarized by region and statewide.

The office receives UR data from the UR nurses and analyzes and summarizes the data and prepares a report regarding community hospitals. They have access to the community hospital data admissions and discharge data. They perform the same analysis for hospital data. QI housing information is received from a variety of sources, including class member surveys, goals data, and unmet needs data. Data regarding residential support services is received at his office through quarterly contracts, performance indicator data, some questions on consumer surveys, and grievances. This information is tracked by his office, as are the critical incident reports. BRAP and SPC are no longer in his office.

The QI plan revised 5/9/02 is currently in effect. *See* Jt. Ex. 21. p. 68412 (adult mental health sources).

The office receives data regarding crisis services, including quarterly reports from all contract crisis providers, including statistics for where the crisis services were provided, whether the crisis service was face-to-face, and the disposition, including the number of people who went to the hospital as a result of the crisis, how many went to a crisis stabilization bed, and how many have community supports. These indicators were developed by a working group in 1998.

Dr. Yoe chairs the Performance Measures Group and has since its beginning. The group meets now only monthly, although they met weekly for several years. The regional QI managers provide information. They review the indicators and then the performance indicators are set for the upcoming year. These data sources were in place before 1/02.

With regard to performance indicators, the Performance Measures Group recommended removal of the client satisfaction indicators. The agencies used different ways to gather that information and interpretation of the information became a problem. This problem will be addressed during the next year, 2003.

Consumer satisfaction has been excluded from the performance indicator database in the 2003 contracts. *See* Defs.' Ex. 68A, p. 2; Defs.' Ex. 68B, p.-71906. The agencies all use different types of satisfaction surveys so the data provided no reasonable way to make judgments about it. Dr. Yoe argued that the Consent Decree does not require the Department to conduct consumer satisfaction surveys "specifically."

***179** In total, his office conducts four surveys. The class member community survey and a similar survey at AMHI are conducted. *See* Defs.' Exs. 69A & 70A; *See* ¶ 279. These surveys were revised on 2/14/02 and 1/25/02, respectively. The first survey was conducted in 1999. The office has a contract with an organization to conduct the class member community surveys. These are done almost exclusively by telephone and are done by peer interviewers, who are prior or current consumers of mental health services. They receive training from the QI Department on the method for conducting the surveys.

A random sample of class members is selected but those who say they do not want to be contacted by the Department are excluded. The sample is completely instate and his office provides 1,000 names to the community support specialist program, which conducts the interviews. The survey is done one time a year, typically in January or February. A typical sample size is approximately 111. There was no testimony that the sample was statistically valid.

The 2002 class member survey data of 111 class members included 45 additional members surveyed separately. *See* Defs.' Ex. 66 (dated July, 2002). In 2001, there were 82 responses to the survey; nothing was done to supplement the 2001 number of responses. In 2000, the number of responses was approximately 80; nothing was done to supplement the 2000 number of responses either. When the 2000 and 2001 surveys were conducted, no comparison regarding demographics was done. The 2002 survey was the first time the Department compared demographics from that survey and any other database. The comparison could have been done previously. This July, 2002 survey is not considered on the issue of the defendants' substantial compliance as of 1/25/02.

The annual class member hospital survey is not provided to a random sample. *See* Defs.' Ex. 70A. The community support specialists program workers go to AMHI and interview any AMHI patient who is willing to be interviewed and is able to be interviewed. This is generally done in January and has been done since 1999 on an annual basis. These community and hospital surveys' data are entered into the data system and his office prepares a report to the QI team. *See* Jt. Ex. 22, pp. 73729; 73715.

Consumer experience about how the ISP review is working is collected by peer interviewers. *See* Defs.' Ex. 71A. The sample size has increased over time and is in the 130 range. This ISP consumer survey has been administered ten times to anyone who has an ISP, not just to class members; 949 people have been surveyed in total.

The data are compiled similarly to other data, summarized, and reported. *See* Jt. Ex. 22, p. 73736. The data summary is distributed and reviewed by CDCs and regional management staff.

The ISP consumer interviews provide no information regarding priority clients. The only criteria is that the person have an ISP. The interviews are conducted at the big agencies and the social clubs. If an individual is not connected to an agency or to a social club, there is no opportunity to participate in that survey. For example, ICMs prepare ISPs. There is no way to know if the survey was done by a person with an ISP prepared by a provider group or by an ICM. The Department currently does not survey ICMs in the performance indicator database. There is a recommendation to do that beginning in January, 2003. The ICMs, in place for a number of years, will then answer the same questions as the providers.

***180** The annual class member provider survey was developed by the QI office and CDCs in 2000-2001 and was first conducted in 2001. *See* Defs.' Ex. 72A. This survey is administered once a year, typically in August, by the regional CDC offices. Its purpose is to check the status of all class members in CSW, ICM or ACT services regarding housing and services and to determine if people waiting for services. The data go to the QI office from the CDCs. A data system is established and a summary is distributed. This data will soon be part of the quarterly QI review. Previously, it was a stand-alone report. The report is distributed to the Regions, the program management staff at central office, and to the Court Master.

The QI plan was revised in late fall, 2001. *See* Jt. Ex. 21. Revisions were made because it was awkward to have all programs having ongoing reviews. They determined to focus on program teams' responsibility for decisionmaking and provide a link to the EMT. The process took some time. The fall, 2001 changes are now in draft form. *See* Jt. Ex. 21. The principal difference between the QI plan revised 9/25/00 and the recent draft is the focus on the QI review for the program teams. *See* Jt. Exs. 20 & 21. The result of the process is a grid map for the QI review process for adult mental health. These changes were implemented in 1/02, before the final draft came out.

The twelve program areas were determined by input from program and management, a review of the Consent Decree, and consultation with the Court Master. *See* Defs.' Ex. 63. A person in each area with knowledge and experience was identified to be the lead writer. The QI office provided summaries of data to those people, as well as a format and structure for the report and conclusions. In September, 2000 the first reports were completed and then updated. *See* Defs .' Ex. 64. These reports have not been produced since 12/01 because the format was not manageable in terms of involving the numbers of people. As discussed, these are the reports that were discontinued with no notice to, or consultation with, the Court Master.

The role of QI office has changed since the revision to the QI process in the fall, 2001. Before 1/02, the Department envisioned the QI office as doing everything and the office became more of a consultant providing information and guidelines. Since 1/02, the office has developed a system to make formal recommendations. Dr. Yoe's discussion of the revisions after 1/02 is not considered.

The Department was awarded a three-year data infrastructure grant in 10/01. *See* Jt. Ex. 27. The objective is to have a common set of data elements in the state. The Department applied to continue the grant in the fall, 2001. *See* Pls.' Ex. 36. As a result, the grant continued at the rate of $100,000.00 per year for three years. In that 10/01 grant application, the Department stated that it currently lacked a consistent data collecting mechanism for some variables and admitted that it had no consistent and reliable mechanism to capture service encounter and performance data for community hospitals. *See* Pls.' Ex. 36, p.-6/16.

***181** The grant will fund development of performance indicators to help integrate data sources in to the Enterprise Information System (EIS). This system is intended to ensure that the data system is adequate and representative. The Department will have data regarding outcomes by 10/04. The link to provider agencies in not operational and is in the testing phase. The change to EIS has been delayed and no data have yet been sent to EIS because the Department did not want to address that task while it was in court.

The adult mental health QI teams make recommendations. *See* Jt. Ex. 22, p. 73669; Defs.' Ex. 67. The Regions receive the recommendations from QI, discuss the recommendations, and submit them to central office. The recommendations are reviewed to determine which will go to the EMT and which to the Regional Director if they are regional specific. The teams can cull some recommendations or send them to the regional team for further review. The recommendations will not appear on defendants' exhibit 67 unless they have specific action. Not all recommendations are entered into the system and not all recommendations from the regional team will be seen by the central office QI team. This is the "distilling" of information before it reaches the decisionmakers that is troublesome.

Dr. Yoe was involved in the decision to file the notice of substantial compliance. The decision was discussed in a group setting with Ms. Smyrski, Ms. Harvey, Ms. Sandstrum, and Ms. Burdick. As of 1/25/02, he believed that QI was in substantial compliance regarding internal monitoring, evaluation, and QA even though as of 1/25/02, the only reports available regarding paragraph

279 were in defendants' exhibits 63 and 64. The revisions to the system began in the fall, 2001.

Dr. Yoe argued that paragraphs 275 and 279 do not require an entire review process. He did not need all of the information to make the determination of substantial compliance. He stated that the twelve QI reports and the updates that are sent to the Court Master are evidence of where the Department is in terms of compliance with the Consent Decree. As of 1/25/02, however, the Department had discontinued those reports. As of 1/25, the Department did not have a final plan; Dr. Yoe thought that the Department submitted a draft plan to the Court Master in April or May, 2002. When asked whether as of 1/25/02, he knew how the revised QI process would work, Dr. Yoe responded that the Department knew that the process was in place, that it would be refined, that it would be an improvement. In other words, the answer was "no." Dr. Yoe's testimony supports the other evidence that shows that the defendants have done too little, too late to provide any valid assessment of compliance with the Consent Decree.

Michael DeSisto is a licensed psychologist in Maine and Massachusetts. He practiced clinical psychology and has been employed in the field of psychology and mental health since 1978.

***182** He was involved in aspects of QA while working at AMHI. In 1/76, he started as a MHW at AMHI and in 1977, he became staff psychologist. From 1977 through 1980s, he developed a psycho-social rehab program at AMHI for long-term patients who had been "on the back wards" and were trying to get out of the hospital. He called the program "moving and breathing." He took a developmental approach and taught people how to do such fundamental things as start a conversation and give compliments. The patients had previously simply been sitting in chairs. The patients liked this program and began coming to the classes with their hair done and "dressed up."

In 1978, he became Chief of Psychology and was involved in QA for the AMHI and dealt with JCAHO. He was also involved in QA at BMHI. He was acting Superintendent in 1986 for six months. He conducted needs assessments for the hospital and met with the staff and patients. He was Superintendent at BMHI for one year.

From 1980s through 1986, he was the Director of the Bureau of Mental Health. He was responsible for AMHI, BMHI, community programs, licensing, and the quality of the system as it was conceived at that time. This was a transition period, when the federal government moved from giving money to community agents to giving money to the states. It was also a time of change in the focus on persons with serious mental illness; the idea was not just to treat people but to rehabilitate them.

As Director of the Bureau of Mental Health, he was involved with the mental health system as a system and has visited many mental health systems around the country. He developed a Maine Community Systems Workbook, which is a QA tool. The workbook described systems and posed questions based on what an ideal system looked like. The systems could score themselves based on these principles. He determined that the mental health system needed a blueprint based on rehabilitation rinciples. That tool was used until it was "derailed" by the new Commissioner. He decided that people needed support as well as treatment, counseling, medication, and rehabilitation. Mr. DeSisto considers the workbook still relevant currently because there is no other good tool available to assess systems in terms of state and local mental health agencies.

From 1989 through 1990s, he returned to AMHI as the Chief Psychologist. He left the Department in 1990s to become the Director of Medical Care Development. From 1990s through 1993, he helped start residential programs in Bucksport and in Auburn. Class members lived in the Auburn facility. He developed the programs, trained the staff, and did Medicaid assessments. His primary role was Director of Research. He designed the process to ease the transition to the group home in Auburn from AMHI.

Quality management has been the focus of Mr. DeSisto's employment for ten years. In 1993 or 1994, he became the proprietor for an organization called Outcomes, Inc., which helps organizations with QI and program evaluation. From 1994 to 1996, he worked for the Maine Health Care Association, where he helped conceptualize a QM program. He wrote the plan, conducted focus groups, and developed and tested surveys. The plan was incorporated in the proposal for the QM system.

***183** In 1995, for the Office of Consumer Affairs, he conducted 60 focus groups regarding the needs of mental health consumers across Maine and he helped to set up the database to record responses. He wrote the QI section of the Department's proposal for a mental health improvement grant; the Department received the grant. He conducted focus groups regarding consumers in the service system and developed the survey and the report. He had started to test the survey when the project was aborted because the Department decided to take a different approach. He attended the Department's QI work groups at Dr. Yoe's request and did workshop outcome measurements for central office.

From 1996 and ongoing, he has worked with the Division of Vocational Rehabilitation conducting a statewide satisfaction survey and working with the team on methods to use the information. In 1997, he worked at the Bureau of Elder Adult Services to define an outcome performance

based budget; the thought was that the budget should be based on performance.

In 1996, he worked for CHCS in Bangor and performed an assessment in order to meet the JCAHO accreditation for community support programs. He set up the database for a survey on functional assessment. He trained the staff at the Together Place to conduct focus groups and to develop a satisfaction survey for a statewide community recreational program.

He facilitated an effort by the DHS to understand the barriers to recruiting children for the Children's Insurance Program. He worked on a strategic plan for the Maine Health Care Advisory Committee. In the Kennebunk High School, he designed a system that people could respond to electronically and organized responses and ranked them and sorted them.

In 1997, he worked for Medical Care Development, where he developed long-term care surveys and helped the staff analyze responses. He also was involved in the Community Support Specialist Program, which involved consumers who would like to work in the system and taught the courses for the program. From 1998 through 2001, he worked at Maine Medical Center Vocational Services. He developed a database and analyzed data to assess programs for people with multiple barriers.

In 2000, the Department asked him to train consumers to conduct focus groups on issues of loneliness and isolation because the Court Master had flagged that area as needing exploration. In 2000, he also performed an evaluation for the Franklin Memorial Hospital and UMF with regard to cardiac programs.

Mr. DeSisto also taught various psychology courses and conducted research for four years at Colby College. He was involved in teaching and supervising graduate students, which was the beginning of the MHRT program. He taught statistics and psychology at University of Maine at Augusta in the late 1970s. In the 1990s, he taught the required courses for the MHRT II Program. He currently works with the Maine Transition Network in the Department of Education.

***184** He has testified in court as an expert in Maine in the Superior Court hearings regarding a forensic assessments, as a consultant in involuntary hospitalization cases, and in prior trials in the *Bates* case with regard to QI and financing. He performed clinical assessments with regard to whether class members could be released from the Maine State Prison but those cases did not require court hearings.

The court accepts Mr. DeSisto's conclusions for several reasons. His experience at AMHI and the fact that the Department asked him to do work in 2000 supported his credibility and provided a basis for his opinions. He was not arrogant and did not appear to have any particular agenda. In fact, he was complimentary of the Department on certain issues. Finally, unlike the defendants' experts, Mr. DeSisto's conclusions were supported by the credible evidence in the case. No credible evidence from the defendants' witnesses contradicted the inescapable conclusion that the Department has established no standards with which to measure the data it collects and that the Department cannot, therefore, monitor or evaluate its performance.

He was asked in March, 2002 to review QI material and reports obtained by the DRC. He reviewed and relied upon the information listed in plaintiffs' exhibit 47 for his opinion regarding the Department's QI system, surveys, and unmet needs. ¶ 279; *See* Pls.' Ex. 47. As noted, Mr. DeSisto articulated very well the problem with the Department's allegation that it has complied with paragraph 279: "you can not just say you are doing wonderful things, you have to show, you have to document." It is necessary to state what will be done, by whom, and when. It is necessary to state the indicators to be used and the data to be collected for those indicators. It is necessary to state the standard by which the data will be measured to determine progress. Incrementally, you come up with "work that works."

His opinion, which is discussed below and which the court accepts, was that the Department, through the annual class member community survey, tried to do too many things. *See* Jt. Ex. 22, pp. 73715-73718. He would have conducted at least three surveys, although it would have been more expensive to divide the survey to a more appropriate length.

The survey was too long. It was conducted on the telephone, which would have required one-half to one hour. That time frame requires significant effort from the person responding to the questions. There are further limitations on telephone surveys. Not everyone has a telephone, particularly a population that is on disability or fixed income. Further, people with serious mental illness are mobile and their phone numbers change often.

The survey was administered by students at home. He has worked with the students who do surveys and on-site supervision of administration of surveys by these students is preferable. Although Dr. Yoe testified that students had been given 1,000 names, there was no information or report regarding the method for selection of the names, the sample design, or how many people could not be contacted. Information about the sample design would have permitted an evaluation about whether the responses were representative. A random sample provides that every person has the same likelihood of being selected. The goal is to survey a sample that is efficient and cost-effective. Given the stakes for this survey and the fact that the

survey was used to assess quality improvement, technical information was needed.

***185** The larger the numbers or responses and the more representative the sample, the better the ability to generalize from the responses. In 2001, the Department received 82 responses; in 2002, 66 responses; and, seven months later, 45 additional responses for a total of 111 for 2002. It was not clear where the 45 supplemental responses came from. The combining of data from the small samples of 66 and 45 responses is not done frequently because of the obvious lack of control: "the world changes." Any number of things that cannot be controlled could affect the subsequent 45 responses. For example, the Department itself reports quarterly. A mental health system can change very abruptly if a policy changes. Significant numbers of changes can occur in seven months, depending on the "policies of the day."

Further, the survey questions result in the number of respondents changing from question to question. For example, the first question reads "Do you receive services"? The second question reads "If you do not," and then a further question. Different numbers of people will answer the first and second questions, which will affect the standard errors and confidence intervals.

He ran confidence intervals for the first twenty questions and satisfaction items and recovery items. For this survey, generally there was a ten to twelve to twenty percent confidence level. Ninety-five percent is an acceptable level. An increase in the confidence level would require a shorter survey with more respondents to the survey. Considering the size of this class, up to 600 surveys were necessary because as the number of surveys increases, the number of errors decreases; 66 responses provided too much error.

When Mr. DeSisto conducted surveys, he talked to users of the service. He wanted to know what the perception of the user was. He does not distinguish between a definition of needs and a definition of perception of needs He does not believe that someone else knows more about needs than the person who has the needs. The definition of quality has to do with meeting user expectations. There are a lot of stakeholders in the public system, but the most important stakeholders are the ones to be helped.

In order to assess class member needs, the population of class members is multiplied by the percent who say they are not getting services. That product is multiplied by the number who say they want or need services. A confidence interval is applied, resulting in a certain profile of need using the survey data. The highest needs were dental, education, vocational, in-home supports, and daily living. *See* Jt. Ex. 22, p. 73715. This provided a different needs profile from other data. On the ISP document review, the unmet needs were very small: of 1265 ISPs reviewed, 74 had unmet needs documented, which is approximately 5%. Because that did not appear accurate, goals not achieved were considered, which was the recommendation of one of the twelve QI reports. Mr. DeSisto looked at other sources of data with regard to unmet needs documented in the ISP. For the class member survey, 40% responded that all needs were not being met.

***186** Mr. DeSisto concluded that the situation demands a formal needs assessment, or at least another survey and to determine who responds. From the data available, and mostly the Department's own data, there is a fairly substantial number of class members who have unmet needs. Depending on the need, there are hundreds of people with unmet needs. This is an important question because only 38% of class members are availing themselves of what the Consent Decree provides. The number of class members who are not in service and want to be and want ISPs or CSWs is 230; these people do not go through the ISP process regarding unmet needs.

Mr. DeSisto described QI as an effort over time to increase the sophistication of people who perform measurements: collecting, analyzing, and monitoring data to improve key processes incrementally over a period of time.

QI is test of an hypothesis for change to determine whether the change causes a favorable result. The process is cyclical. If an issue arises, a plan is devised, which includes reviewing all processes relating to that issue and which includes a determination of the baseline measure. Changes to improve the process are implemented and the process is measured to determine whether the changes resulted in improvement. If there is improvement, the process is monitored; if not, different changes are attempted. He describes this process as "plan, do, check, act." The process to improve quality must involve measurement and must be selective. Areas to be improved must be prioritized.

Mr. DeSisto concluded that the Department's QI processes and plans for compliance with paragraph 279 are improving but the system is not competent to answer important quality questions. Further, the Department is not selective. There were 104 recommendations from the QI reports; monitoring 104 recommendations is excessive for a QI process.

There are no indicators, which shows that the Department does not understand the relationship between process and outcome measurement. QI requires commitment to a limited number of known measures or standards for quality. Compliance indicators should have been identified for the requirements of the Consent Decree that are not specifically quantified in the Consent Decree. Standards are available to be adopted, such as licensing

standards, or standards can evolve from the QI process. QI should not and does not have to wait for national standards to evolve.

Mr. DeSisto concluded that the action memos from the QI methodology were so seriously flawed that the Department cannot know whether to make a change. There are measures in the field, including the availability of services, continuity of the service, choice, satisfaction, effectiveness and performance indicators are included in contracts. But none of these is a standard.

The Department engages in efforts that could potentially improve quality, but there is no data to suggest that they do. For example, time is devoted to training in trauma issues. There is no method to determine whether this training improves the trauma services because there is no data linked to any indicator or measure to evaluate whether the system has improved its dealing with trauma issues. The Crisis and Hospital Initiative Group is described as an initiative to improve coordination. This is not a QI activity because there is no measure of the outcomes of these efforts. There is a lack of understanding of the need to assess the work that a person does and whether that work is effective. The Goals Tracking Project also is not a QI project. *See* Jt. Ex. 22, p. 73629.

***187** Mr. DeSisto concluded, and the court agrees, that the Department has not established required, critical standards for quality. The Department has avoided committing to a measure that it thinks is acceptable. There has been no comparison of the data with any standard in the Consent Decree to determine the Department's progress. In a QI system, the compliance standard for the Consent Decree has to be identified and known. The defendants have not done that. Mr. DeSisto concluded, and the overwhelming evidence in this case supports the conclusion, that "it is as though [the Department though that] monitoring is enough."

Raymond Gorman is the Director of Community Health Centers in Groton and New London, Connecticut. He has overall responsibility for a large primary healthcare clinic. His staff is 60 people, including a medical director, doctors, neurosurgeons, nursing staff. He oversees the administrative component of the clinic as well. He has an Associates Degree and received a Masters Degree in 1991 in Human Services Administration.

He has managerial experience in the field of human services. For twenty years, he has been involved in senior management in healthcare delivery in community settings, non-profits, public entities, and state agencies. He has experience with monitoring and funding services.

He was the Administrative Director of a mental health center in Connecticut with four affiliate members called CMHA, which included two acute care general hospitals with psychiatric components and two social service clinics. At that time, the Connecticut Department of Mental Health did not fund in-patient acute care therapy. His responsibility included funding and meeting requirements for the agency to begin providing direct care.

After leaving CMHA, he worked for the Department of Mental Health as Assistant Regional Director in Region Four in Connecticut, which had a population of slightly over one million people in 1986. The services provided were full range, community support services to build an integrated service network. Regional service plans were developed for what was needed in terms of services, case management, and programs. In the following years, each area that was identified in the plan was funded and developed. As the Assistant Regional Director, he worked with community agencies. He responsibilities included reporting requirements, planning, forecasting to get the resources to work with grant agencies, and citizen advisory groups.

He next worked with a trade association group, The Association of Children's Care Agency, representing the members' interests in obtaining rate relief and working with the legislative process and public information. This organization provided mental health services. All members were licensed residential treatment centers providing room and board for children and clinical services.

Next, he became a Deputy Commissioner for the Department of Mental Health in Connecticut. He was the only Deputy Commissioner when he began in 2/95. The Department of Mental Health then became the Department of Mental Health and Addiction Services. At that point, he was a Deputy Commissioner of Mental Health and was responsible for the adult population served by the Department. He had responsibility for the overall budget to ensure that programs complied with the contract demands or specified goals.

***188** One significant responsibility for Mr. Gorman in this job was the closure of two state psychiatric hospitals and the necessary increase in services for the remaining hospitals. Of the two hospitals that closed, each of which had 100 -120 patients, 75% of the patients were discharged to the community.

The Connecticut Legislature approved the plan to close these facilities. He ensured that compliance was achieved with the legislative deadlines. He dealt with client and family apprehension. He worked consistently with the Governor's office on finances to ensure that they were not putting the community at risk. He worked with the long-stay facilities to ensure that the staff was trained. There were significant union issues because workers were

transplanted and given new duties. He had signatory authority on all grants and community services and did a great deal of contract work.

In 1997, he was nominated by Governor Roland and confirmed as Commissioner for the Connecticut Office of Healthcare Access. In 1998, when Governor Roland was elected to a second term, Mr. Gorman was again nominated by the Governor and was again confirmed for that position. In the early 1990s, the Connecticut Legislature changed the focus of the organization toward more involvement in planning. The office became proactive in raising healthcare issues and access to healthcare. The office was highly regulated with certificate of need requirements. The Legislature charged his office with preparation of special reports regarding healthcare issues and he was responsible for the final product. He ensured that the reports were readable, accurate, and conveyed clinical information, and information regarding services. The office prepared eight or ten legislatively mandated reports and discretionary reports per year, was aggressive about producing reports, and did not always wait for the legislature to mandate a report. His office collected data and decided how to use the data.

He dealt with regulations governing discharges and the database contained thousands of pieces of information. The hospital had to report regularly; the process emanated from the certificate of need process. The hospital began to use data to drive the system's ability to meet patients' needs as opposed to a reactive focus. Decisions about current or future funding decisions were based on data collected.

As the Deputy Commissioner, he determined the types of data that service providers were required to submit. Certain data and filing requirements were required from all agencies. Additional data was requested from others, depending on the office's experience with the organization. Special reporting requirements were required if the office determined that a shorter reign on an agency was required. A client identification system was developed to permit the office to get unique data regarding each client. Data were collected with the goal of answering the following questions: how many people are provided service, are their clinical needs being met, is there access to client records if an incident occurs, and the cost of the services. A cost/benefit review regarding services was implemented. The flow of information was critical in terms of the flow of dollars.

***189** His office was able to track a patient and the patient's progress. The Connecticut Department made great strides to seek and use consumer input; area councils were advisory and had strong consumer representation. The Connecticut Department was committed to getting consumers involved in the planning of services. Data were helpful when consumer satisfaction surveys could be quantified. For example, information regarding the amount of money consumers spent on housing could be quantified; information about whether a consumer was happy where he lived could not be quantified.

Budget information and information regarding clients in the state hospitals were part of an overall review for decision-making services. Mr. Gorman removed funding from one provider if he thought that another would do a better job providing services.

The Connecticut Department used QA people or outside people to develop the actual tools to collect data. He gave final approval. The QA managers reported directly to him and were part of his executive team. Connecticut's mental health system had a QA plan and an extensive QA department.

Mr. Gorman was retained by DRC as an expert in this case. He had never testified before as an expert. He examined documents including the Consent Decree and QI reports. *See* Defs.' Ex. 132. His knowledge of the Maine community mental health system comes from the documents he reviewed. He did not speak to Department staff. He was asked to give an opinion about whether these documents assisted in testing the quality, sufficiency, and adequacy of services and whether the data complied with the requirements of the Consent Decree. His focus was on the community side. He was not asked to give an opinion about AMHI.

In early August, 2002, he reviewed the QI plan, reports from consulting agencies, data runs generated by the Department, and six-month reports regarding service areas involving indicators. He reviewed but did not rely on the Clinical Services Management Report. He familiarized himself with the Consent Decree to understand its intent. He looked at reports that the Department generated and compared them. He looked at QI process and plan information sent from the regions to the Department and regional assessments of data. He assessed whether the information used to develop services was collected uniformly and whether it was used to make resource allocation decisions.

Based on his experience, Mr. Gorman was qualified for the task assigned to him by the DRC. Mr. Gorman's conclusions echo those of Mr. DeSisto and are supported by other credible evidence in this case and by the defendants' documents. His conclusions, in part, were based simply on a comparison of the defendants' reports.

Mr. Gorman concluded that some standard, objective, or benchmark, all synonyms, must be established as the goal for the system. Different benchmarks or standards can be established for different types of services but the

fundamental question must be "what do we want to accomplish?" QA permits the system to evaluate how it is progressing and evaluation permits the system to consider how close the system comes to meeting the goal or standard and whether the standard should be revised.

***190** Monitoring involves a determination of the mechanism used to gather the information: what type of information does the system have to test whether the standard is met? Uniformity of information in terms of type and time frame is required. After the standard is developed, the information is reviewed to assess whether the standard is met and whether the standard is still relevant. Situations can change. For example, the previous thinking required that there should be no vacancies in residential programs. That has now changed because if the goal is 100% occupancy rate, a person released from a hospital will have no bed available.

He reviewed the Department's QI reports and the underlying data in electronic form on a CD. *See* Defs.' Exs. 63, 64. He concluded that the 7/01 QI report does not suggest that the data are useful in making decisions regarding the quality of programs. There is no predetermined threshold or standard that the Department provided to its contractors. There is, for example, a discussion regarding waiting time but because there is no standard established for an acceptable waiting time, the Department is not making progress toward any goal. *See* Defs.' Ex. 63, Treatment Services, p. 9. If the Department had established a standard, it could compare the regions' progress. With no standard, data only describe an event and cannot be used to measure progress. The 7/01 report does not show that the Department is developing treatment options that are responsive to class members' needs. In the report, the Department does not conclude that resources will be used to meet any standard.

The report reflects that statewide utilization of mental health services increased 36%. It does not appear that that fact triggered a discussion that the Department must add services because of the volume of the increase or that services must be decreased because people are accessing service are not within the target population. The report does not show that the data collected generate changes in the way resources are distributed or services are provided. The reports have tremendous amounts of information that remains simply collected information and does not lead to any conclusions regarding services. The information does not show how close the Department is to meeting goals. If the standard is not there, the data are just numbers. As Mr. Gorman explained on cross-examination, all of the meetings scheduled by the Department may be important but unless a definition of outcomes and standards is discussed and is used to value accomplishments, the meetings are meaningless.

A comparison of the 7/01 and 12/01 QI reports reveals no accomplishments achieved or progress made toward any standard or goal. There is no change in the content of the reports to help determine availability and effectiveness of services. Accordingly, a discussion regarding the effectiveness of the system is not possible, although that is the expectation of QI. Further, because the reports include no financial data, a cost benefit analysis is not possible.

***191** A review of joint exhibit 22 did not address Mr. Gorman's concerns that the 7/01 and 12/01 QI reports are not useful in assessing compliance and in making managerial decisions. For example, a comparison of the 2001 and 2002 class member survey data involves no discussion of an accomplishment or standard for the acceptable or desired level of response. *See* Jt. Ex. 22, p. 73715. This data have no utility in determining whether goals are satisfied. There is no suggestion that the data show compliance with the Consent Decree or shows any improvement for any population responding to the survey. Other data in the report did not help to determine where the resources are being used.

Similarly, the 5/9/02 report includes significant amounts of data but no articulation by the Department of a benchmark. *See* Jt. Ex. 21. Although the organizational structure may be appropriate, the discussion of "distilling" QI information indicates difficulty giving information to upper management. If information is generated at the local level and then "distilled," the validity of the information may change or be lost. *See* Jt. Ex. 21, p. 68383. That potential is especially true if the Regions do things differently, as is clear from the evidence. There are no tests for accuracy. The Department is now involved in a national collaboration to identify standards in data collection, management, QI, and QM. *See* Jt. Ex. 21, p. 68396. This potentially will allow for meaningful comparison of data collected throughout the State.

The documents reveal great concern that the Regions are doing things differently. Simply allowing a comparison of one gross number to another gross number for Regions, which may or may not assess things in the same way, does not produce useful information.

Mr. Gorman reviewed the regional records. *See* Jt. Ex. 22, p. 73669. The records make clear that the regions are struggling with the types of data to be collected, which is inconsistent with the contract regulations. The agencies in the field report that the contract requirements are not always met. *See also id.,* p. 73672. The Region II QI Meeting minutes dated 2/8/02 provide:

"Most information is basic, bare bones data." The information does not measure:

If consumers are getting better

Quality of treatment received

Performance of agency. Does the agency provide good or bad services? What is their caseload? Is the service cost effective?

Characteristics of the people served by the agency ... What is the acuity level of the clients? Do agencies pick their clients?

No comparison to number of people statewide or in region who are eligible for services?

Do not look across services areas to study the services provided to people. Do not tie performance data to financial data?

See Jt. Ex. 22, pp. 73676-77.
The critical incident database contains information but no process or review based on the data is included to permit the managers to look at critical incidents and learn from them. There is monitoring but no ability to anticipate and avoid problems in the system. There is a great deal of data but it is not being used to increase the system's performance or outcomes for the clients.

***192** Indicators are not useful with no standard or measuring device for accomplishments or utilization. Such indicators, without more, can not answer questions regarding quality, access, cost efficiency, and other information a manager would want to know. *See* Jt. Ex. 21, p. 68396. Many indicators have yet to be developed. *See id.*

Although the contracts required reporting on certain performance indicators, there was no definition of which indicators providers should use. Performance indicators alone will not solve the problem because the regions fear that they are doing things differently and the regional teams are concerned about performance indicator data. *See* Defs.' Exs. 68A, 68B. For example, for the indicator, "Timely Access to Psychiatric Services," there is no definition of "timely." *See* Defs.' Ex. 68A. Gross numbers do not provide measurement and the people at the regional level had raised that exact concern. There is disparity among the providers regarding interpretation of rules and reports. In the spring, 2002, the Department began to clarify definitions for agency reporting regarding the CSW waiting list, which supports the conclusion that the definitions previously were too broad and not consistently interpreted. The resulting data, therefore, was not reliable. In an evaluation design, there must be clear structure of data and clear definitions of what to report and how to report so that the comparison is "apples to apples."

Incredibly, Mr. Gorman was asked by defense counsel on cross-examination whether, in a case in which there may be a dispute regarding a measure of quality, would it be a good idea that the Department not set a standard that may be objected to? He responded that if a state agency is required to develop a system of evaluation and monitoring, it is in everyone's best interests to agree at the outset on a quality indicator. With regard to the Consent Decree, a agreed standard would have precluded hiring experts to assess the situation years later. Mr. Gorman found nothing in his review that shows the Department's compliance with the requirements of paragraphs 279 and 280.

The Commissioner appeared to agree, at least in part, with Mr. Gorman. In discussing the new QI Plan filed in April, 2002, she stated that the Department changed the way it took information from regional offices to the central office and to send information back to the regional office. The QI plan was changed because the previous plan needed improvement. The Commissioner wanted to make sure that the regional offices had direction so that the Department could identify trends at the state and local level. The Commissioner did not state, however, that any standards had been specified.

Commissioner Duby admitted that the Department has not endeavored to develop a reporting system for each requirement of the Consent Decree but she thought that QI and QA tracked each requirement of the Consent Decree. She said that the Department can generate data regarding compliance with each requirement of the Consent Decree. That "thought" is simply not supported by the evidence.

***193** Superintendent Kavanaugh noted that AMHI has begun a management information system and the data entry person was hired in 2/02. E-chart is the electronic medical record system; parts of this system became functional in late summer, 2002. The assessment aspect is expected to be operational in the spring, 2003. She became aware of E-chart in March, 2001. The State of Utah has used E-chart for at least three years. There was no explanation for AMHI's failure to implement this type of system previously.

The defendants presented the testimony of two experts from Clinical Services Management (CSM), a consulting firm in New Jersey. Their opinionsare accorded no weight in the court's decision for several reasons. First, and most important, the experts did what the court declines to do: they accepted the defendants' representations and relied on the their reports and compilations. As discussed below, the accuracy of the underlying data was assumed and not checked. As Mr. Pastras stated, data guide decision-making. These witnesses concluded that the defendants' system was capable of collecting accurate and reliable data based on these assumptions, which are not supported by the credible evidence in this case.

Second, their review, by their own admission, was very circumscribed. Limitations because of time and expenses are understandable but such limitations do not transform a very complex and difficult problem into one that can be assessed by a very superficial review of isolated topics. Mr. Pastras said that if he had gone into detail, he would have lost the breadth of his review. This case is, however, about detail. Mr. Schwartz, in particular, did not appear particularly prepared or conversant in the subject matter.

Third, for reasons previously stated, reliance on the Consent Decree requirements, as opposed to JCAHO requirements and NASMHPD indicators, is preferable in assessing compliance with the Consent Decree.

Fourth, the experts spoke only to the defendants' representatives and counsel. Both experts spoke with Ms. Briggs, whose testimony was essentially rejected by the court. The Court Master was not interviewed. Mr. Pastras never spoke to any consumer groups and received no information directly from community providers. He did not speak to plaintiffs' counsel. Although he said he believed such discussions would have been inappropriate, he sought no permission from the court or the plaintiffs' attorneys to speak to anyone because it was beyond the scope of what he was asked to do. He focused on leadership in the Department and at AMHI. The team had no contact with the defendants prior to 1/25/02.

Mr. Pastras did not interview Dr. Grasso, in spite of Mr. Pastras's interest in the period prior to 1/25/02, when Dr. Grasso was the medical director at AMHI. Mr. Pastras said that he was process focused and looked to clarify things-he reviewed so it was not clear whether he would have wanted to speak to Dr. Grasso. Mr. Pastras agreed, however, that the Medical Director in a mental health institution is a key person. He agreed also that if the former medical director was extremely critical of the way QA actually worked at AMHI, Mr. Pastras would have been interested in the reasons for that criticism and he may have looked in some different directions.

***194** Fifth, their conclusions are contrary to the credible evidence presented at trial.

Peter Pastras works at the firm on a full-time basis and has had a number of management rolls at CSM. CMS has several components: (1) direct service provisions, employee assistance programs, mental health and chemical addiction services; (2) contract management and clinical case management services for crisis and residential, outpatient services, crisis intervention for hospitals, outsource management, and remedying failed behavioral health services; and (3) consultative.

Mr. Pastras also has a part-time clinical practice in marital counseling. *See* Defs.' Ex. 74a. His has experience in managing behavioral mental health from program level to director of behavioral health services. He has managed inpatient, drug and alcohol, crisis intervention, outpatient, children, and youth and family service. He was the coordinator/director for a residential program funded by New York City to move people from shelters to housing.

He has participated in QM teams in virtually every organization he's been involved with. His degree was a multi-focus clinical practice, with training in program management. He receives ongoing performance improvement training. He was a team leader of the first performance improvement team in a New Jersey hospital and was responsible for running the hospital's own performance improvement program. He led a hospital through a HCFA survey; he reviewed and evaluated all the services against the credentialing process of HCFA. He served on the board of the National Psychiatric Alliance, a collaboration of private psychiatric hospitals and acute care psychiatric divisions.

He oversaw the development and evolution of ORYX, an outcome measuring system required by JCAHO. He served as chair of the acute care systems review for a large county in New Jersey. He developed QA indicators for a New Jersey state psychiatric hospital. He reviews statistics from state hospitals and developed a structure for reporting data from the hospitals. He was a liaison for the mental health advisory board, a legislatively mandated board similar to the QI council for the service networks in Maine. He has assisted agencies going through the JCAHO review process.

He has experience evaluating healthcare systems. For example, he designed and performed the quality assessment of the New Jersey statewide REIC (Regional Early Intervention Collaborative) system. He designed and performed a study under a subcontract for a large hospital system in New Jersey with regard to individuals with mental illness and developmental disabilities. He has also provided statewide counseling and training services and has done assessments of systems as part of litigation.

Mr. Pastras testified that his team produced a written report because he attempted to reach conclusions that were meaningful and went beyond the lawsuit to move the system forward. He said that because truth is critically important and this lawsuit will have a profound impact, he wanted the group's perspectives and the findings to be available. He said the structure was expansive and that there was a lot of subtlety and conflicted opinion about the status of service systems. It was important, therefore, to provide truthful, reality-based information. In spite of this mission, no determination of the accuracy of the defendants' data was made.

***195** He tried to develop with the Attorney General's office a method to come to grips with the assignment. He

said this was a massive task because the Consent Decree is an expansive document, which covers all aspects of the system. He first looked at Consent Decree to determine how to do a QM approach regarding paragraphs 279 and 280.

Mr. Pastras took a QI approach to the assignment. The question of whether Maine was in compliance with the Consent Decree was beyond the scope of what was performable or reasonable for him. The defendants said they were in compliance; the negative indicators were provided by the plaintiffs' response and the Court Master's reports.

He tried schematically to break the task down. He identified themes: with reference to paragraph 279 and the QA system: (1) is this information accurate; (2) is this information complete; (3) was this information analyzed; (4) was it returned to practice. He tried to look for clear indicator areas because, he said, testing anything in a vacuum is problematic and context is really important. He made a choice to look for external comparisons and he bifurcated the community and hospital services.

AMHI

Mr. Pastras wanted to drill down using a benchmark process and for AMHI, he decided JCAHO could serve as an investigative tool. The team determined that the JCAHO accreditation had existed through out the time the Consent Decree was in effect and would provide a basis for determining what had occurred during the accreditation process. *See* Defs.' Ex. 74f.

Because the Consent Decree is a very specific document in many ways, he performed the review to see where the Consent Decree was compatible with JCAHO standards: did the Consent Decree paragraphs fit generally in the functional standards of JCAHO. He concluded that there were many parallels and decided that an external benchmark process could use the JCAHO standards. Even Superintendent Kavanaugh testified about the many paragraphs in the Consent Decree that were specific or unique to the Consent Decree. For the reasons stated above, the court does not accept JCAHO as relevant to a determination of substantial compliance with the Consent Decree.

The JCAHO accreditation standards are divided and organized by function: (1) individually-focused functions such as patient rights, assessments, care, treatment of patients, ethics, and continuum of treatment; (2) organizationally-focused functions such as performance improvement structure and leadership. *See* Defs.' 74G. Using JCAHO as a tool, the team performed four main probes for the benchmark process: (1) analysis of the 1991 JCAHO survey of AMHI and the 2001 JCAHO survey of AMHI; (2) use of ORYX data for comparison; (3) use of JCAHO data for specific areas of concern; and (4) a comparison of ten state psychiatric hospitals with AMHI in terms of overall scores and the JCAHO review of the QM systems in those states.

He obtained the 1991 and 2001 survey and reports for AMHI and tried to draw comparisons. There were 35 overall standards in 1991 and 47 in 2001. He concluded that the 1991 JCAHO survey of AMHI was indicative of an organization that was performing poorly. The 1991 review showed profound operation problems of a severity requiring significant corrective action. He believed that the scope of deficiencies in the 2001 survey do not indicate the depth of problems or types of concerns as were present in 1991. He was aware of the two contempt and sanction decisions filed after JCAHO had accredited AMHI.

***196** JCAHO uses ORYX to steer the healthcare field toward core measures. In the early 1990s, JCAHO introduced performance improvement and began to move to QI. Several years later, JCAHO determined that scientific benchmark processes were needed. JCAHO created a mandate, which was very expensive for the industry. The hospitals can choose the vendor and the indicators, which are different measures of QA. The hospitals gather the data, send the data to the vendor, and the vendor creates a comparison among the hospitals. AMHI has adopted ORYX-related measures, as have most hospitals. AMHI chose the NASMHPD indicators. This system shows the hospital how it performs on a grid and what the norm and ranges are. As noted, the NASMHPD indicators do not track for the Consent Decree requirements.

After discussion with Michelle Briggs, he looked to four indicators: (1) client inquiries; (2) restraint; (3) seclusion; (4) elopement. AMHI had done its own calculations; he relied on AMHI's calculations for comparison to the norm. He formed an opinion "highly favorable about the performance of AMHI." This opinion is contrary to the credible evidence in this case; the opinion is rejected and negatively affected the court's consideration of the remainder of Mr. Pastras's testimony.

Mr. Pastras stressed that this ORYX data are new; 2002 is the first year the data will be incorporated in reviews of hospitals. For reasons that were not clear, he said he had a reasonable level of confidence in this new data; he had high hopes that this was competent information. This was the primary external evaluation used.

He was unable to state which requirements of the Consent Decree do not have ORYX standards. He did not consider whether it was appropriate for the Department to have no numerical standards for Consent Decree requirements prior to the development of ORYX or for areas for which

ORYX provides no standards.

With regard to the ten state study, he compared AMHI to ten states regarding performance improvement. He considered the scoring breakdown and overall findings of JCAHO. He then considered whether the hospitals were required to take corrective action. In 2001, based apparently on four months of data, AMHI's initial score was 89, which was then upgraded to 94. He compared this score to 27 hospitals in 10 states identified. He documented the results of the comparison. *See* Defs.' Ex. 95, Table 4. He concluded that the performance of AMHI is within the sphere of its peers; AMHI was average. In the 2001 AMHI JCAHO accreditation, AMHI received a supplemental recommendation, which required no action. AMHI will be reviewed again in three years because four months of data collection is insufficient to permit JCAHO review of compliance. *See* Defs.' Ex. 96a. This 2001 review is, however, one basis for Mr. Pastras's opinion.

He agreed that JCAHO was in existence in 1990s, when the Consent Decree was signed, and the JCAHO standards could have been incorporated into the Consent Decree. Although he believed there are parallels between JCAHO and the Consent Decree, he agreed that some parts in the Consent Decree are not covered by JCAHO.

***197** He did not look at BMHI because that hospital was not brought to his attention. He did not know if BMHI was accredited by JCAHO. He did not know whether any part of BMHI's license from the DHS was conditional. If he had known that BMHI had a conditional license and did not operate under a Consent Decree, he would have inquired further about what that meant; he said he would need to know more.

He answered "yes and no" to whether it was possible for AMHI to be accredited by JCAHO and not in compliance with the Consent Decree regarding AMHI regulations. Because JCAHO regulations provide that a hospital has to follow its own regulations, the Consent Decree requirement with regard to counseling hours, not found in the JCAHO regulations, would have to be followed. He agreed that the AMHI could have JCAHO accreditation and fail on performance improvement.

Based on his review of the performance of AMHI, with a specific focus on QA, QM, and QI structures, he concluded that AMHI is functioning in a manner equal to or above the norm of state psychiatric hospitals in the country. Further, based on his understanding on the Consent Decree, AMHI is clearly meeting the requirements of paragraph 279. He stated that based on his limited probing, if the QM processes of AMHI say that it is in compliance with the Consent Decree, AMHI is in compliance with the Consent Decree. Mr. Pastras's opinion, based on, among other things, new ORYX data, indicators that do not track for the Consent Decree requirements, and conversations with Ms. Briggs, is contrary to the credible evidence in this case and is not relied on by the court.

Community

Because QA and QI are both branches of QM, Mr. Pastras looks at both accuracy and completeness of data and analysis and feedback into practice. He looked at the following in the Consent Decree for accuracy and completeness of data: vocational issues; socialization; public education; crisis services; counseling hours; the AMHI survey and the community survey; the palm pilot project; and ISPs. He did not look at raw data and did not attempt to test the accuracy of the raw data in any of these areas because that was not the design of his study. Primarily, the team just looked at reports, presumably the same reports the court has found incomplete and self-serving. For example, he did not look at patient records for the forensic unit. He said that would be a primary data source and this was a secondary study.

Mr. Pastras did not interview Dr. Grasso, the leader of the palm pilot performance improvement project. The purpose of the palm pilot project was to create a way to improve doctors' ability to prescribe medicine based on the perception that there was a problem with medical errors. Mr. Pastras did not know if medical errors decreased; he did not check. He did not use the palm pilot project as an example of the performance improvement process. He said that the depth of his probe limited what he could do. They looked at the process the system has to address its own problems.

***198** Mr. Pastras concluded that the Department meets the standard in the Consent Decree regarding monitoring, evaluation, and QA mechanisms regarding public education. He stated that gauging the effectiveness of public education is tremendously difficult and expensive but he did not find any negative indicators regarding public education. He concluded that there is no reason to devote more resources to public education.

He reached this conclusion without speaking to Catherine Sanborn, who was in charge of public education; he spoke to the people responsible for QM. He did not review anything except a report on public education before he gave his opinion regarding QM of public education. He said it was not an error not speak to the person who wrote the report. Although he took a deeper look at public education, he did not do a thorough review. As noted above in section XIII, the testimony of Ms. Sanborn made clear that the Department did not meet these standards for public education as of 1/25/02. Mr. Pastras's conclusion to the contrary, once again, did not add to the credibility of his work.

In his consideration of paragraph 99(e), Mr. Pastras did not interview crisis providers. He did not read the Diamond report, produced when the Department last reviewed the crisis system. He said that the plaintiffs and the Court Master's concerns based on the Diamond report would have affected his opinion if he were doing a focused review but not based on the review he performed. He stated that if the Department had hired an expert regarding crisis, he would have to know more about the situation.

In spite of the Court Master's concern outlined in his 12/01 report that the crisis is not operating according to Consent Decree standards, Mr. Pastras reviewed the QI report for crisis and the data sources involved and found the numbers "unremarkable." *See* Pls.' Ex. 67. Mr. Pastras found no negative indicators.

He could not go point by point, detail by detail through the Consent Decree; he drilled down only in certain core areas and created a context for his opinion. Based on his reading of paragraph 279, he found clear and overwhelming evidence that Maine has created a QA system to measure and track the community mental health system. He determined that the system meets professional standards, and, therefore, for reasons not explained, the Consent Decree standards. The bases shown for this conclusion are not sound, this conclusion is contrary to the credible evidence in this case, and this conclusion is not relied on by the court.

Richard Schwartz is an independent consultant with CMS. He is also a licensed psychologist and has a private practice. He has a Ph .D in psychology and has practiced for fifteen years as a licensed psychologist. He has had experience in developing and administering mental health programs and was the director of inpatient mental health services at St. Clair Hospital in New Jersey from 1987 to 1992. With regard to QA and QI experience, he has a certificate in continuing QI and on-the-job experience. *See* Defs.' 74a. He has never testified in court on behalf of plaintiff consumers. Although his work is not always for state agencies, his work involving litigation has always been for state agencies.

***199** According to Mr. Schwartz, the task, with the help of others from his organization, was to provide an expert opinion regarding the Department's compliance with the Consent Decree. Specifically, the team reviewed the Department's QM efforts to determine whether the Department was able to provide accurate information and sufficient analysis through those efforts and whether the Department's system was able to meet the requirements of the Consent Decree.

Mr. Schwartz reviewed 88 documents. *See* Defs.' Ex. 74h. The team focused on the Consent Decree, the defendants' most recent compliance report, the plaintiffs' response to the defendants' notice of substantial compliance, and the July and December, 2001 Court Master's reports.

On further examination, it was difficult to determine the documents Mr. Schwartz had reviewed because he was unable to recall with any specificity the documents he reviewed. Defendants' exhibit 94A purportedly was the list of documents he reviewed but he did not review that list for completeness. *See* Defs.' Ex. 94A. For example, in his deposition, he said he did not believe he read numbers 70-75 thoroughly. He said he reviewed parts of 70-74 but did not recall which parts. He reviewed parts of 76-83 and parts of 84-86. He reviewed a QI plan but an iteration prior to joint exhibit 21. After defense counsel showed him page 34 of his report, he then said he thought the discussion was regarding the 1996 plan and he knew the 4/3 QI was in his report. He then said he knew he reviewed joint exhibit 21. Exhibit 94A does not include joint exhibit 1 but he said he did review that document but not in its entirety. He knew he looked at joint exhibit 1 because the "bluebook" is famous because it is so large and so difficult to get through. He did not address the last sentence of paragraph 102 and, therefore, had no opinion about compliance with that requirement.

Mr. Schwartz stated that the team concluded that it was too difficult to judge compliance with the Consent Decree by reviewing each area of the Consent Decree, especially because of the level of detail involved. The team also concluded that it there are too many measurable parts of the Consent Decree to go into the detail found in the plaintiffs' response to the notice of substantial compliance dated 3/6/02. Because the team was not able to look at all areas of the Consent Decree, the team decided to probe in depth one or two areas to determine whether "there was validity" in the whole system. Mr. Schwartz testified that is standard methodology in oil drilling and in social services research.

According to Mr. Schwartz, QA is a system of measurement to insure that standards and thresholds are met. QI is a much more team-oriented process. It continues to address problems identified by QA indicators. QM is an amalgam of all systems involved in QI and QA. When he decided that the QA system could not answer the question of compliance, Mr. Schwartz determined instead to look at the Department's QM system to determine what the Department had in place to assess and improve its system. He developed an approach to do the following: test the accuracy and completeness of information gathered by the QA program and compliance review as well as to compare the QM system at AMHI and in the community against outside standards to determine whether the system was guided by the standard in paragraph E(8) of the Consent Decree.

***200** He determined that there are really two separate QM

systems: the AMHI system and the community system. Based on his review of the 9/20 plan and the 4/02 plan, he concluded that there was a process of improvement in the plans. *See* Jt. Exs. 20, 21 (4/02 version).

Community

With regard to the Consent Decree, he probed for the community side only paragraphs 33; 63, part of the first sentence and part of the second sentence ending with the first use of the word "ISP; 39; 72; 99e, fourth sentence only; 101; 102, 1st sentence only; 279; and 280, first sentence only.

He reviewed the QM program in the community internally and using external benchmarks. He reviewed the QM plan and the Consent Decree requirements and looked at QI activities, which he concluded were not required by the Consent Decree He determined that QA in paragraph 279 meant QA and he would not expect it to mean anything else. Although he stated that nothing in the Consent Decree made him think that QI was required, he did suggest that paragraph 279 implied doing a review to insure something. His conclusions about QI and the Consent Decree, which the defendants have intermittently espoused, are inaccurate.

He met with various people, including Dr. Yoe, the CDCs, the Region II QI team, Brenda Harvey, Joan Smyrski and Sharon Sandstrum. *See* Defs.' Ex. 74I. He concluded that there were a number of QI processes, specifically performance review teams, to look at systemic changes. These are more frequently found in hospitals and not in the community. He also reviewed the reports for the twelve QI areas outlined in the 4/02 report and testified that these are highly organized reports with a specific outline and represent not a true QI process but the beginning of a QI process. He concluded that the reports were consistent in terms of outline and core questions. He determined this was a good beginning step toward QI. These reports were subsequently discontinued.

He looked at the annual class member surveys to determine whether the surveys were capable of producing accurate and reliable results. He said there was no way access the underlying data. Accordingly, he assumed the data were accurate. He had no direct knowledge regarding the data. He did not interview anyone who collects data for the community class member survey or the AMHI class member survey. He did not analyze the data for trends or for specific problems. He believed he looked at the contract performance indicators data but he had no idea if that data were accurate. He did not analyze any of that data for trends. He had no idea why the system decided to supplement the survey. Based on his assumption of accurate data and based on his conversations with Dr. Yoe, Mr. Schwartz concluded that the surveys are capable of collecting accurate and reliable information. He believed, however, that there were too few responses in the 01/02 survey. Based on the credible evidence presented in this case, the survey process was flawed and Mr. Schwartz's conclusion is not relied on by the court.

***201** In addition to the class member survey, he analyzed other QI tools, including vocational services, EIS, and the management information system. He examined vocational services because the Court Master and plaintiffs noted a lack of sufficient analysis and application to performance improvement. He reviewed vocational services to determine whether the process of continuous improvement was based on data collected. He determined that since 1990s, a series of improvements occurred in the delivery of services to class members. He concluded that the Department's use of quality planning mechanisms in the 1995 vocational services plan was an important part of the improvement process that lead to significant changes in the number of class members served in the division of vocational rehabilitation and a very significant decrease in the waiting list. Because he did not address the last sentence of paragraph 102, however, he had no opinion regarding compliance as specified by that sentence.

He reviewed the timeliness and completeness of the ISP process for the same reasons he reviewed the vocational services. He reviewed the issues raised by the Court Master and the plaintiffs, who identify the lack of analysis and application to performance improvement. He concluded that the Department made significant changes based on QA data with regard to how ISP training takes place and to improve the timeliness and completeness of the ISP process. He concluded that the changes made a very significant difference. This conclusion is contrary to the credible evidence in this case and is not relied on by the court.

He looked at the report to see if unmet needs were being addressed by the system. He determined, correctly, that there was a tremendous amount of confusion in the system with regard to the meaning of unmet needs. When asked on redirect examination whether the ISP-identified needs were being met by the mental health system in Maine, he was unable to remember accurately his opinion.

He used a benchmark study to assess QM and QI to determine whether the defendants were meeting standards consistent with the standards in the field from JCAHO and HCFA. He developed, with the help of Mr. Walsh, the survey tool used to measure statewide mental health improvement plans. *See* Defs.' Ex. 74C. He chose a sample. *See* Defs.' Ex. 74B, pp. 4-8. He used five states in addition to Maine: New Jersey, Louisiana, New Hampshire, Vermont, and Rhode Island. The sample size of five was based on time and expense considerations. With regard to these other states, he had no idea whether

any of those states were subject to a state or federal consent decree. A person was found to administer the tool in five states in order to insure an arm's-length relationship between Mr. Schwartz and the research. He used a stratified random sample with the stratification weighted by participation in the data infrastructure grant, state size in terms of population, and Medicaid spending. The survey involves a 10% sample of the country.

***202** The tool was administered by Michelle in his group. He gave her the procedures and gave her instructions about what to say on the telephone. He did not discuss the case with her. He forwarded the Consent Decree to her and instructed her quite specifically how to administer the tool. She returned the completed data forms to him and to Mr. Walsh. Mr. Schwartz instructed Mr. Walsh to enter the data in a computer and compile scores and compile a content assessment based on the forms from Michelle. He compared her sheets with the compilation done by Mr. Walsh and analyzed the data. He concluded that Maine's QM systems meets or exceeds QM systems in the other states and that the survey provided an objective comparison. He concluded further that Maine's QM systems collects accurate and complete information and uses the data to drive budget processes, to continue improving performance, and to inform the continuous improvement performance process itself. Once again, these conclusions are contrary to the credible evidence in this case and are not relied on by the court.

AMHI

Mr. Schwartz also reviewed AMHI's QM processes specifically. He had not seen a document which identified all the Consent Decree requirements for AMHI and did not know the number of Consent Decree requirements that applied to AMHI. They did not develop a tool to assess AMHI's compliance with all the requirements of the Consent Decree because their process was to do only probes. He chose to probe the palm pilot project, counseling hours, whether AMHI meets JCAHO and HCFA standards, and the patient satisfaction survey.

He met with the AEC and he reviewed the QM plan for AMHI. He met with Michelle Briggs, at that time the QI coordinator for AMHI. He reviewed the documentation of counseling hours because that was identified in the plaintiffs' response as an area of noncompliance. He reviewed the counseling hours report and he spoke with the administrative executive counsel. He asked for the process for recording counseling hours, asked how time was spent by each discipline in recording counseling hours, and looked at the sheets.

Initially, he looked for ways to test the accuracy of the underlying data. He knew that the nurses' charting was governed by their licensing standard. Accordingly, he assumed that the charting numbers were accurate because the nurses would be jeopardizing their licenses if the numbers were not accurate. He stated that the only way to determine accuracy would be to put a camera in AMHI; the only way to know what went on would be to be there. When asked whether he tested any of the underlying data independently for accuracy as part of his review for AMHI, he responded that he tested JCAHO data independently and he looked at JCAHO review data. He did not independently test any other data. Nevertheless, he concluded that an extraordinary amount of effort is put into the accuracy and completeness of information regarding counseling hours. This conclusion is contrary to the defendants' witnesses' testimony.

***203** He also reviewed the patient satisfaction survey. He spoke to Dr. Yoe, the AEC, and Michelle Briggs He was aware that there were different surveys used and he did not know if he looked at the most recent survey. Further, he did not look at the actual completed survey forms from AMHI. He did not compare those survey forms to the requirements of the Consent Decree. Accordingly, he did not know whether the survey gave feedback on Consent Decree requirements that may not be required in other states. He concluded that the survey was capable of collecting accurate and complete information, that it was continuously improved, and the tool complied with national benchmark standards. This conclusion is meaningless in the context of the issues contested at trial.

He also reviewed the palm pilot project to determine whether AMHI had functional performance improvement teams, which are an indication of the QM process. He determined that AMHI uses performance data to continuously improve its processes, that AMHI has a competent and effective QM program that collects accurate and complete information, and that the information is analyzed to improve performance. The program meets or exceeds standards recognized in the field regarding QM systems.

With regard to the entire mental health system, he concluded that the QM system in Maine is capable of providing the system with accurate and complete information. The information produced is used for important processes, including budgeting. His concluded further that the Department's QA system continues to improve itself to ensure that class members and other consumers in Maine receive the highest quality services available. The bases for Mr. Schwartz's various opinions are not sound. The opinions are not supported by the credible evidence in this case and are rejected.

The Court Master also testified about the defendants' compliance with this paragraphs. Mr. Rodman's office is at the AMHI complex. He has a significant amount of contact with AMHI administrators and central office administrators. He meets with the Superintendent, the

Clinical Director, the CDCs, and others regarding Consent Decree issues. During the last two years, his activities included resolving specific disputes and reporting to the court. His most common activity was working with the parties to develop a manageable system to organize information and place the defendants in a position to demonstrate compliance with the Consent Decree requirements. He has engaged in an open discussion with the parties and point people for the Department.

He has had contact with class members and family members, although these contacts are not regular. Early on, he conducted public forums required by the Consent Decree. Other than those, his contacts are informal. The class members or family members contact him with their concerns and he usually refers them to a CDC.

He maintains a list of people who do not want contact from the Department. A determination is made whether to put a person on that list. He receives requests for no contact in response to the quarterly letters.

***204** Mr. Rodman agreed that his education regarding the delivery of mental health systems consisted of on-the-job training. Initially, he focused on Maine in order to determine the appropriateness of the delivery of the mental health services. But over the years, he has drawn on literature and information from other states. He has not looked to other states to form opinions regarding Maine's system but he has considered what is being done in other states, including innovative approaches.

The parties engaged in discussion regarding paragraph 291 in early 1991, near the time of the first general information plan of 4/91. Mr. Rodman asked the parties to consider establishing a process regarding paragraph 291. The plaintiffs submitted written suggestions for a process to evaluate compliance and the defendants filed a written response. The defendants opposed an additional process in terms of evaluating compliance and believed that the Consent Decree had adequate process and additional process was not necessary. They elected not to add additional process for paragraph 291 to evaluate and measure the defendants' compliance with the terms and provisions of the Consent Decree. This issue was not revisited. The defendants have submitted numerous plans since 1991, which contained measures and standards. The defendants have proposed implementation of various measures and standards for progress.

The Department attempted unsuccessfully to try to develop an overall QI system in the early 1990s. The Department's 1991 plan included a section regarding QA and internal monitoring, which paralleled paragraphs 274 and 279. *See* Pls.' Ex. 82 (excerpt from 1/1/91 Implementation Plan, approved 11/91). The plan specifically provided that "[t]he roles of contract review and quality assurance are to assure certain levels of performance and facilitate a process of continuous improvement in services. Each of these functions rely on standards which can be used to monitor, evaluate and subsequently improve services." This plan contradicts the defendants' position that QI is not required.

Additional development occurred with the Department's 5/96 plan. The Department anticipated a large management information system but implementation did not occur in 7/97 as projected. The CMA was developed subsequent to 1997. The EIS was in various stages of implementation at the time of trial. During all iterations, the various systems were developed to meet the requirements of paragraphs 275 and 279. He reported to the court that the 5/96 plan was extensive, unnecessary, and beyond what the Department was required to do.

The Department's method to evaluate the system and to meet the requirements of paragraphs 274, 275, 279 and 280 was the subject of the 5/96 plan. There was another large plan approximately one year before the 5/96 plan. All plans included sections on systems to fulfill paragraphs 274 and 279. He approved the 5/96 plan, subject to reservations.

***205** More recently, standards have evolved and have been adopted explicitly or implicitly in the QI process. For example, the Department determined that upon discharge from the hospital, a patient would have prescribed medicine to last fourteen days. The Department then looked at the average time each patient required to see a psychiatrist. In deciding whether a person saw a psychiatrist within a reasonable time, the defendants determined that a reasonable time would be determined by the fourteen-day supply of medicine. Mr. Rodman was amendable to that type of process in developing standards, unless the plaintiffs objected to a particular standard. He was more concerned with analysis of data than the particular standard itself.

The parties discussed the provision of case management services by independent agencies that provided mental health services. An agreement was reached with the Department, which the Department later failed to honor. *See* Pls.' Exs. 72, 73. There was no follow-up with independent case management services. The Department submitted no documentation for plans discussed in Commissioner Peet's letter. *See* Pls.' Ex. 73.

In his reports to the court, Mr. Rodman has expressed concerns regarding the Department's QI data. The initial QI reports were filed in the fall, 2000; the first formal QI report was filed in 7/01. *See* Defs.' Ex. 63. There was extensive discussion by the defendants regarding the shape of QI reports and Consent Decree evaluation in terms of QI reports. That report was the subject of one of his reports to the court. Although he believed that the

defendants' QI reports were improving, he was not satisfied with the presentation of data. He was concerned about the analysis of available information, the lack of information, the need for more detail and analysis, the need to consider the range of value, and the implications of the data to achieving goals.

For example, with regard to crisis services, the defendants' report provided that follow-up in crisis cases occurred 23% of the time. In the defendants' QI report for crisis, the question under which that information was analyzed was whether follow-up occurred "whenever necessary." That was the standard established by the defendants for that requirement. From the information, he could not determine whether they met the standard of "whenever necessary" or the standard in the Consent Decree respecting the capacity to respond on multiple occasions as needed. He looked at the information and could not tell if the 23% follow-up rate meant as needed. The Department assumed that was a reasonable response rate. Mr. Rodman found many other instances where analysis was shallow or lacking.

The class member surveys could be used as an indirect tool in assisting assessment of unmet needs. The questions are, however, general and the survey does not identify specific needs or geography. For example, the question reads, "Do you have a housing need?" It is difficult to use that information for planning or budgeting because it is not quantifiable. Mr. Rodman asked the defendants to follow up with persons who identify needs. The Department does not analyze data regarding people who want to pursue needs. Mr. Rodman did not agree that paragraph 74 required a system to identify mental health system development as opposed to identifying individual needs. He believed that Department was not in compliance with paragraph 74.

***206** Similarly, he considers the Department's contact with class members and families as useful information. But because there is no documentation as a measure of QI regarding such contacts, there is no way to quantify those contacts as part of a QI/QA system.

Although the Department hired NAMI to review family support services and the Department submitted NAMI's report as evidence of compliance, Mr. Rodman considered the report as inconsistent with compliance. Although the Department said it would work with NAMI on the issue, that work did not occur.

Mr. Rodman responded to the Department's 12/01 QI update when he filed his 12/01 report. *See* Defs.' Ex. 64; Pls.' Ex. 67. Any processing he would have done at that time was ending because of the 1/02 filing of the notice of substantial compliance. There is an expectation in paragraphs 274-279 that there will be a process to change the previously approved QI plan. In the 12/01 compliance report, the defendants stated that they would review and revise the QI plan and file a QI plan in May, 2002. The 12/01 compliance report did not indicate that the twelve QI reports would not be refiled, but the May, 2002 plan excluded those twelve QI reports. *See* Jt. Ex. 21; *see also* Defs.' Exs. 63-64. The Department did not advise Mr. Rodman that the QI reports would be discontinued. His first notice that the reports were not refiled was when he read the 2002 QI plan and noted that the twelve reports were not included.

The Department sought no approval from him about a method by which to submit QI and QA information and the Department has not sought approval since that time. Mr. Rodman believed that the defendants should have come forward with new plans to review and discuss before the implementation of the plans. The Department's 2002 QI plan is inconsistent with previous plans. The Department has an obligation to develop a system of quality management to show that individual needs are being met. In his report to the court dated 10/02, Mr. Rodman expressed concerns about this procedure and discussed the function of the QI reports with regard to the paragraphs 275, 279 and 280 regarding monitoring, QA, analysis, and budget. *See* Pls.' Ex. 68.

Mr. Rodman requested copies of all material produced by the defendants during discovery; for that reason he has seen materials prepared by the Department subsequent to the filing of the notice of substantial compliance. He had not seen the Mental Health Program Team Quality Improvement Review prior to the filing of substantial compliance. *See* Jt. Ex. 22, pp. 73582-73668. The Department filed a quarterly report within the last few months prior to his testimony but the report included supporting information only and no narrative.

In the fall, 2001, he discussed with the Department its readiness to file a notice of substantial compliance. He continued to find that the Department did not fulfill the requirements of paragraphs 274, 275, and 280; that opinion was the subject of a report to the court. The QI reporting process was not formally included as a process or in a plan. Mr. Rodman was "very definitive about [his] opinion that they were not in compliance at that point." After he received the QI updates from the Department in 12/01, he filed his report, in which he addressed the issue of compliance. He received no further submissions from the Department after the QI updates in 12/01 and his report in 12/01 until the notice of compliance was filed in 1/02. In April, 2002, the Department submitted to Mr. Rodman a one-page supplement to the notice of substantial compliance titled "Paragraphs 275, 279 QI." In this document, the Department claimed compliance with paragraphs 275 and 279.

***207** Since the beginning, the management information system at AMHI has been the key to reporting and

understanding the system. Mr. Rodman has been dissatisfied with the information available with regard to training, seclusion and restraint, and medication information. At times, there has been an "enormous dearth of information." He has promoted E-chart, the management information system. This system will require broad-based training of employees at AMHI and the hiring of consultants because E-chart has to be adopted to a specific system.

As of summer, 2002, AMHI was still considering how the Consent Decree requirements could be part of E-chart. He has discussed the paragraphs regarding the Consent Decree requirements with AMHI people and tried to lead the hospital into an evaluation of the requirements in the Consent Decree. In 1997 or 1998, he went through the AMHI portions of the Consent Decree to determine if policies applied and were on point with the Consent Decree requirements. He wrote a memo to Jan Halloran, in which he stated that some of the policies addressed the Consent Decree and some did not. His efforts did not lead to AMHI's monitoring every paragraph of the Consent Decree.

With regard to AMHI, he believed that the filing of the notice of substantial compliance was premature due to concerns about training, treatment, the involvement of the CSWs, and the development of a management information system that will permit AMHI to maintain and monitor services. His concerns regarding crisis services include utilization of community support units, in-home supports regarding crisis services, back-up in the emergency rooms, lack of access to hospital care, misuse of blue papers, inappropriate modes of transportation, a lack of documentation regarding residential support services and lack of family support services. The JCAHO accreditation of AMHI and DHS and CMS licensing do not relieve Mr. Rodman's concerns regarding appropriate documentation of treatment.

Mr. Rodman believed that AMHI is approaching an era of self-monitoring with regard to determining whether it can meet the Consent Decree standards. AMHI is getting data but that does not mean that the data show that the standards are being met. More has to be done in terms of community support work and training in the provision and documentation of treatment.

Mr. Rodman's general, overriding concern involved the Department's QM system's inability to demonstrate persuasively that class members' needs are being met as required. The Department does not have to prove an absence of problems, but the Department has an affirmative obligation to show that people's needs are being met; the Department has an affirmative burden to demonstrate compliance with the requirements of the Consent Decree. Simply reciting a fact does not establish that the fact represents an appropriate level of activity. The defendants have to report but they have to do more than just report.

***208** Mr. Rodman was present for the entire trial. None of the testimony at trial changed his opinions outlined in the 12/01 or 10/02 reports or his opinion that the defendants are not in substantial compliance with the requirements of the Consent Decree. In fact, his concerns regarding forensic patients receiving CSWs were heightened by the evidence. In addition, Claire Harrison's testimony that individuals are told when they enter a residential facility that the length of their stay is predetermined is contrary to his decision regarding residential care facilities.

Progress Reports

In these reports, the defendants were required to describe efforts made and progress achieved and to note areas where compliance has not been achieved. They were to document claims of compliance. The court has accorded very little weight to these reports in its decision. In general, the reports are self-serving and incomplete. In some cases, the reports are inaccurate. *See, e.g.,* § VII, ¶ 110.

Enforcement of Regulations

Ms. Gianopoulos and Ms. Smyrski testified about paragraphs 282-283.

As of 1/25/02, the defendants were not in substantial compliance with paragraphs 274-276, 278-280, and 282-283 of the Consent Decree.

PART II

Prior to 1/25/02, the Court Master was not personally consulted by the defendants regarding his position on compliance. He communicated to defendants' counsel his opinion that the filing of the notice of substantial compliance was premature, based on reasons outlined in his recent reports to the court. As of the dates of his testimony, Mr. Rodman had not been approached by the defendants regarding consolidation of the Department with the DHS.

Paragraph 284 provides, in part, that "[t]he parties agree to the appointment of a Master to monitor the implementation of this Agreement." The defendants have interfered with the Court Master's ability to monitor the Consent Decree by their intentional failure to communicate with him, disregard of his decisions, and failure to honor commitments made to him and the plaintiffs. The defendants' failure to solicit the Court Master's opinion regarding substantial compliance and

their failure to heed his opinions, outlined in his reports and communicated to defendants' counsel, were indeed unfortunate.

Paragraph 8 of the Consent Decree provides that the "Court shall retain supervision over the implementation of the Settlement Agreement...." This court has employed various approaches to supervise and encourage progress by the defendants toward substantial compliance with the Consent Decree: a finding of contempt, the threat of a receivership, frequent meetings, and numerous requests for information. In spite of these efforts, effective supervision has been difficult and information has not been forthcoming from the defendants. Under these circumstances, the court finally was compelled to file its order to show cause in January, 2002.

The defendants and their representatives have taken an obstructive stance toward the court and the Court Master and have affected their ability to perform the responsibilities assigned to them in the Consent Decree. This system cries out for more well-trained and qualified front-line workers, such as CSWs and crisis workers. Many class members testified that their CSWs are trying but are not given authority to get the job done. The defendants vest authority instead in an abundance of management-management that appears to believe it answers to no one.

***209** The parties stipulated that Commissioner Duby resigned as Commissioner of the Department effective 3/1/03 and that Commissioner Concannon resigned as Commissioner of DHS effective mid-February, 2003. Since the conclusion of the trial, the Court Master has tendered his resignation. At the court's request, he has agreed to continue his duties until after this order is filed.

The court will issue Part II of this order in due course. In the interim, all provisions of the Consent Decree remain in full force and effect. *See* Consent Decree, ¶ 6, 8, 14, 19.

The entry is

> As of 1/25/02, the Defendants were not in Substantial Compliance with the above-listed provisions of the Consent Decree.

Footnotes

1 The Settlement Agreement is incorporated as part of the Consent Decree. *See* Consent Decree, pp. 1-3. For the purposes of this order, the term "Consent Decree" refers to both documents.

2 Many witnesses testified about issues found in more than one section of the Consent Decree. In general, the entire testimony of a witness has been discussed in one section. The testimony was considered for all of the issues about which the witness testified.

3 Many class members and their relatives preferred to testify anonymously or with an assumed name.