I. INTRODUCTION

2006 INDEPENDENT REVIEW
OFFICE OF THE MONITOR

I. INTRODUCTION

The purpose of this report is to analyze and summarize the findings of the Court Monitor's October 2006 Independent Review. This review was conducted pursuant to the *Stipulation Agreement Re: Revised Completion Dates* filed with the Court on May 23, 2006. This stipulation was filed as a result of the findings from the 2005 Independent Review.

The applicable requirements of the Stipulation Agreement are:

Class Member Group	Requirement
Priority Class Members @ 6 Targeted Sites 1300 N. Central Alma School Arcadia Metro Center Townley West Camelback	70% have clinical teams which include the client, nurse, physician, case manager and vocational specialist, unless employment has been determined as no longer to be an issue (C.2.). 70% have an ISP with a functional assessment and long term view (C.3.). 55% will have their needs met, consistent with their ISP (C.5.). 72.5% of class members will be involved in the planning and development of their ISP (C.9.).

Aside from assessing the status of priority class members at targeted sites, the 2006 Independent Review will determine the status of priority class members receiving services from the remaining 17 clinical team sites as well as the status of "non-priority" class members assigned to all 23 clinical team sites. There was no specific performance targets established for these two groups in the stipulation. However, the requirements contained in the *Joint Stipulation on Exit Criteria and Disengagement, Appendix C, and the Supplemental Agreement* still apply.

The 2006 Independent Review is an in-depth look at 429 randomly selected individual class members currently residing in the community. The review did not include any individuals

currently in the Arizona State Hospital or in jail. The term "priority" is defined in the *Joint Stipulation on Exit Criteria and Disengagement* to include individual's enrolled in the system as a person with a serious mental illness who:

1. Is or has been inpatient in the Arizona State Hospital (ASH) since July 1, 1993; or
2. Is or has been a resident of a Supervisory Care Home since July 1, 1995; or
3. Is or has been an inmate in jail since July 1, 1995 who has a major biological illness;
4. is or has been a resident of a 24 hour residential program contracted with the RBHA (timeframe-class member will be dropped from this category by not residing in a contracted licensed Level II Twenty-four hour residential provider facility for a period of 24 months following the class member's most recent move-out date from a 24 hour residential); or
5. Has been hospitalized for mental illness twice or more in a year or is a frequent recipient of crisis services.

In selecting the sample for the 2006 Independent Review, the Court Monitor applied the requirements set forth in Appendix C of the *Joint Stipulation on Exit Criteria and Disengagement* which states that when the priority class exceeds three thousand, priority should be given to individuals who, at that time, meet the criteria (1), (2) and (3) above.

To address findings of non compliance from the 2005 Independent Review, Plaintiff's Counsel and the Defendants (ADHS) entered into a *Joint Stipulation to Partially Resolve Plaintiff's Motion for Non Compliance and Further Remedial Orders*. The order was filed with the court in November 2005. The requirements set forth in the stipulation include, but were not limited to, the development of mentoring teams at specific clinic cites to address service delivery deficiencies, on site training from Boston University, and the development of a targeted network capacity analysis and network development plan creating new services for a group of priority class members at five (now six) clinic sites.

In addition to these items, the stipulation required the parties to negotiate new completion dates for each Appendix C requirement and identified a process for strengthening the validity and reliability of the Court Monitor's audit process utilizing the expertise of Dr. Jose Ashford (Court

Monitor's Office) and Dr. Michael Shafer (ADHS). The recommendations of the experts were documented in a written "Statement of Consensus: Suggested Methodological Enhancements for the Arnold v. Sarn Field Review Protocol" (January 20, 2006). The consensus recommendations were incorporated into the community audit process and included the following areas:

1. The establishment of pre field reliability procedures to ensure that field reviewers observe and record data in a consistent manner before conducting community audits. The experts suggested that pre field reliability would be enhanced by reviewing and revising the Court Monitor's audit protocol to eliminate vague terminology, refining definitions and limiting response criterion outcomes to "yes" and "no." The experts also identified a need to ensure clinical competency, by setting minimal qualifications (education and work experience) for individuals serving as field reviewers. As a result, minimum qualifications, for field reviewers, were jointly agreed to by the Court Monitor and ADHS.

2. The consensus statement included recommendations for the training of auditors prior to conducting audits. Comprehensive training was provided to potential reviewers on September 19 & 21, 2006 or September 27 & 28, 2006. The training covered the audit process and protocol content.

3. Consistent with the statement of consensus, four simulation cases were developed and independently audited by representatives of the Court Monitor's Office and ADHS/DBHS to establish the "gold standard" for the training process. Disagreements between the auditors were reviewed with Drs. Ashford and Shafer and resulted in further modification and clarification of the instructions in the protocol (e.g. when to count and ISP complete) or in procedural decisions (e.g. how to handle information documented after the clinic was notified that the case was selected for the audit).

4. The simulated cases were utilized for assessing pre-field reliability of all reviewers prior to their completion of audits. Prior to being assigned a case, each reviewer was required to achieve at least a rate of agreement with established standards of 80% on exit

stipulation questions contained in the protocol. Reviewers who could not reach the 80% threshold on established standards were not hired.

5. To ensure ongoing reliability and consistency during the audit process, one case assigned to each field reviewer was duplicated by another reviewer. Inter rater reliability was calculated for each exit stipulation question to ensure a rate of agreement of at 80%.

6. Individuals in jail at the time of the review would be excluded from the sample. A separate audit of these individuals would be conducted at a later date. Therefore, all persons selected for the Independent Review were living in the community at the time they were selected for review.

7. Both experts agreed that with additional demographic information (e.g. age, gender, ethnicity, priority status, etc), the Court Monitor's Independent Review findings could be generalized and used to determine the external validity in selecting the sample. The Court Monitor complied with experts' request to collect additional demographics to assess the representativeness of the sample.

II. REVIEW METHODOLOGY

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The Case Review Instrument (CRI) used for this audit was Version 22.00. The 2005 CRI was modified by the Court Monitor in consultation with two experts. Based on the statement of consensus developed by the experts, there were many substantive changes/clarifications made to the protocol. The primary substantive changes made to the CRI in 2006 included: (1) the removal of "partial" ratings; (2) expanding and strengthening the instructions; (3) eliminating unclear or vague terms (e.g. adequate, substantial, appropriate, etc.); (4) adding definitions; (5) establishing time frames associated with various requirements (e.g. criteria for how soon a service should be provided after the ISP is written); (6) the data entry of interview responses and development of guidelines for reviewers when conducting interviews, and; (7) the establishment of a method to accept engagement efforts as part of the person's individualized service plan when the person is unable or unwilling to articulate what they want/need. Finally, reviewers determined whether persons' behavioral health needs were/were not met irrespective of what was documented in the person's individual service plan (ISP).

Additionally, the Court Monitor expanded training to reviewers and ensured that each reviewer met the minimum acceptable standard (80%) for pre field reliability on a previously audited simulation case.

A. Auditor Recruitment

An advertisement was used to recruit individuals as field reviewers. Minimum educational, experiential and licensure qualifications, time frames for training and audit requirements were distributed to provider agencies in the community, the Maricopa County RBHA, ADHS/DBHS and contractors recruited by the Office of the Court Monitor. Candidates submitted their resumes to the Court Monitor for screening. Letters were sent to each candidate who met the minimal qualifications inviting them to training. Forty-nine reviewer candidates were provided training.

At the conclusion of training, candidates completed a post-test to determine their understanding of the training material. Following the scoring of the post-test, accurate responses for each question were reviewed with the group. The post tests were collected and tabulated by the Court Monitor for this report. Of the candidates hired as reviewers, the percentage of correct responses on the post test was as follows:

Number of Auditors	Percent of Correct Answers	Valid Percentage	Cumulative Percentage
1	68%	2%	2%
2	78%	5%	7%
11	81-88%	26%	33%
26	91-97%	60%	93%
3	100%	7%	100%
2*	-	-	-
45		100	

*dash=no data

The data shows that 93% of the reviewers scored at least 81% or above on the post test. Data is not shown in the above for two individuals who did not complete the post test. The average score for the 43 candidates who completed the post test was 91%.

B. Pre Audit Field Reliability

Of the 45 reviewer candidates who chose to complete a simulation case following training, 39 (87%) passed the minimum threshold of 80%. Six (13%) of the remaining candidates who did not reach the minimum score of 80% chose to complete a second simulation case. All exceeded the minimum standard of 80% for their second case.

The results of the simulation cases were as follows:

Auditor Results-Gold Standard Cases

TIME 1		TIME 2	
Number of Auditors	**Percent of Correct Responses-1st Case**	**Number of Auditors**	**Percent of Correct Responses-2nd Case**
1	45%	1	83%
1	67%	1	85%
3	70%	1	90%
1	75%	3	100%
9	80%		
11	83%		
2	90%		
8	92%		
9	100%		
45		6	

The range of correct responses for the first simulation case was from 45%-100% with a mean average score of 85%. For the six individuals who completed a second case responses ranged from 83%-100% with an average score of 93%.

C. On-Going Reliability

In order to guard against reviewer drift, one case from each reviewer was assigned to another reviewer to assess consistency in scoring specific cases across reviewers. In the process, 44 cases were duplicated. For these cases, the reviewer's evaluated documentation independently and jointly conducted interviews. The rating of questions in the protocol was completed separately. Dr. Ashford determined the percentage of agreement for each item displayed in the table below and calculated the overall percentage of agreement. None of the items fell below the standard of acceptability of 80%. The percentage of agreement across all items was 93%.

2006 INDEPENDENT REVIEW
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Auditors Results-Ongoing Field Reliability

Exit Stipulation Requirement	Percentage of Agreement
32. Is there evidence that the person/guardian was provided verbal or written consent to take the behavioral health medication? (C11)	90%
33. Is there documentation of informed consent to ECT or surgically related procedures to address mental health conditions? (C11)	100%
46. Was an inpatient treatment and discharge plan developed by the 10th day of the inpatient stay? (C12)	100%
47. Does the inpatient treatment and discharge plan reflect the goals and services of the ISP? (C12)	98%
185. If special assistance is needed, is it currently being provided or offered by ADHS or the RBHA? (C10)	100%
197. If yes, was the person's ISP modified with their consent or consistent with the ISP rules? (C5)	82%
199. For priority clients, was the plan reviewed within the last six months? (C4)	90%
202. The priority client has an appropriate clinical team. (C2)	84%
203. Priority clients have ISP'S with a functional assessment and a long term vision. (C3)	98%
212. Class members are informed of their right to appeal eligibility and treatment decisions. (C6)	90%
216. Did the person participate in the planning and development of their ISP? (C9)	89%
219. The needs of priority clients are met, consistent with their ISP. (C7)	98%
220. For non-priority class members, their needs are substantially met consistent with their ISP or service plan? (C8)	90%
Overall Percentage of Agreement	93%

D. Sample

To measure compliance with the *Stipulation Re: Revised Completion Dates, Joint Stipulation on Exit Criteria and Disengagement, Appendix C, and the Supplemental Agreement,* we employed proportional random sampling and simple random sampling procedures to select priority target, priority non target and non priority cases. The total sample of 429 class members was selected from a data base maintained by the ADHS/DBHS.

Based on data provided by the ADHS/DBHS, there were 3,784 priority class members in the selected groups (e.g. Arizona State Hospital, Supervisory Care and Jail); 1,514 were at target sites and 2,270 assigned to non target sites. Separate sampling fractions were generated to randomly select cases in each of the priority strata (Arizona State Hospital, Supervisory Care and Jail) at rates proportional to the total population in the target (n=142) and non target (n=146) sub-populations. There were a small number of priority cases (n=7) that could not be completed during the review period – priority target (n=2) and priority non target (n=5). This resulted in a sample size of 140 for the priority target sites and 141 for priority non target sites. The confidence intervals for estimating the size of the samples for the two priority group sub-populations were set at 80%. In addition, we employed simple random sampling procedures to select non priority subjects (n=156) at an 80% confidence interval. We were not able to complete data collection for eight (n=8) of these cases. This resulted in a non priority sample of 148 class members.

In selecting the priority samples, a number of subjects had to be replaced because they were in jail. Twelve class members (14%) from the priority target sample were replaced because the current audit procedures prohibit application of the review process to persons incarcerated at the time of the audit. An additional five class members (6%) had to be replaced in the sample because they were incarcerated after the initial sample was drawn.

Comparisons between the priority sample (n=281) and the total priority population were computed to determine whether the sample was representative. These results showed that the sample was comparable for the following variables: age, gender, ethnicity, primary diagnosis and priority status.

Demographic Information for the Priority Class

Variables	Priority Class-Sample (N=281)	Total Priority Class (N=3,784)
Age	Mean= 45	Mean= 45
Gender		
Male	62%	61%
Female	38%	39%
Ethnicity		
White	71%	62%
Black/African American	15%	15 %
Latino	10%	13%
Asian	.7%	2%
Native American	2.3%	1%
Other	1%	2%
Unknown	0%	5%
Priority Status		
Arizona State Hospital	17%	16%
Supervisory Care Home	18%	18%
Jail	64%	66%
Diagnosis		
Schizophrenia/Other Psychotic Disorder	60%	67%
Mood Disorder	35%	26%

The most common living arrangement for all priority clients was Independent Living (41%) followed by Living with a Spouse, Other Family Members or Friends (24%). The table below identifies the living arrangements for the 281 priority class members who were included in the 2006 Independent Review.

Living Arrangements/Priority Class

Living Arrangement	Frequency	Percent	Cumulative Percent
Independent Living	114	40.6%	40.6%
Home with Spouse, Family, Friends	67	23.9%	64.5%
Other	24	8.6%	73.1%
Behavioral Health Residential (Level I,II, or III)	22	7.9%	81%
Homeless/Homeless Shelter	17	6.%	87%
Supervisory Care/Asst. Living	17	6.%	93%
Halfway House/Boarding Home	9	3.2%	96.2%
Hotel/Motel	7	2.5%	98.7%
Client Missing	2	.7%	99.4%
Transitional Housing (Level IV)	1	.3%	99.7%
Nursing Home	1	.3%	
TOTAL	281	100	100%

Class members whose living arrangement is noted as "Other" live in provider sponsored/staffed community placements (i.e. small group homes) with no more than four class members in the residence. This type of group home is preferred for individuals who have a significant history in state hospital treatment and/or incarceration. There were 50 (18%) class members in the sample who were living in the least desired living arrangement at the time of the review. These settings included living on the street or in a shelter, halfway house, supervisory care/boarding home or hotel/motel.

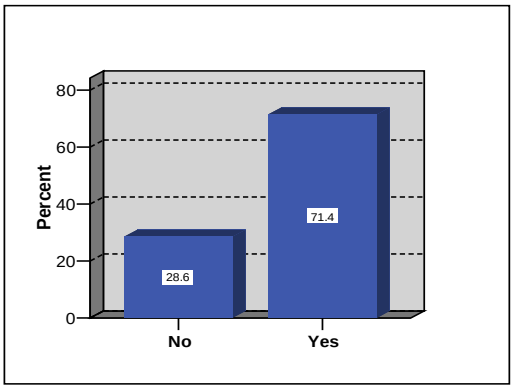
Finally, class members included in the 2006 Independent Review are distributed across all 23 clinical team sites.

Class Member Site Assignment- Sample

SITE	PRIORITY Target Sites Sample=140	PRIORITY Non Target Sites Sample=141	NON PRIORITY all Sites Sample=148
1300 N. Central	42 (30%)		
Alma School	21 (15%)		9 (6%)
Arcadia	20 (14%)		8 (5%)
Cave Creek		17 (12%)	16 (11%)
Cento Esperanza		10 (7%)	4 (3%)
East Mesa		10 (7%)	9 (6%)
East Phoenix		8 (5%)	7 (5%)
Garden Lakes		5 (3%)	4 (3%)
Glendale		3 (2%)	3 (2%)
Heatherbrae		10 (7%)	5 (3%)
Highland		6 (4%)	6 (4%)
Metrocenter	13 (10%)	1 (1%)	6 (4%)
Osborne		4 (3%)	2 (1%)
Park North		11 (8%)	7 (5%)
South Central		10 (7%)	1 (1%)
Tempe		14 (10%)	13 (9%)
Thomas Road		16 (11%)	9 (6%)
Townley	23 (16%)		13 (9%)
Washington House		5 (4%)	3 (2%)
West Camelback	21 (15%)		8 (5%)
West McDowell		5 (4%)	5 (3%)
West Valley		5 (4%)	10 (7%)
Wickenburg		1 (1%)	0
Total	140 (100%)	141 (100%)	148 (100%)

III. DATA ANALYSIS

Priority Class members Target Sites Appendix C Data



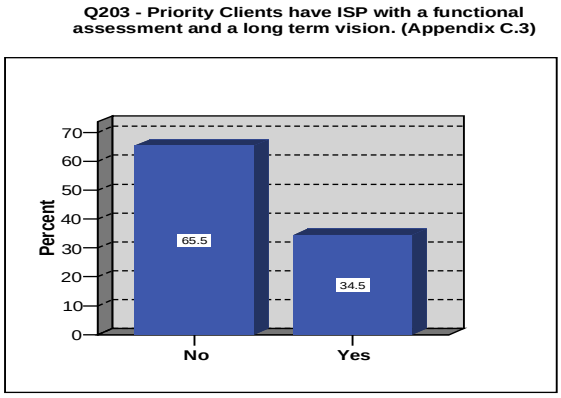
Appendix C, Criterion 2: *Except in the unusual circumstance where the person is properly assigned to the case coordination model, priority clients have a clinical team which includes the client, nurse, physician, case manager and vocational specialist unless employment has been determined by the team and the client to no longer be an issue.* One hundred (100) of the 140 "priority-target site" class members (71%) were found to have an appropriate clinical team. Fourteen (14) of the class members in this review group had legal guardians. Seven (7) of the fourteen guardians (50%) were found to have participated as a member of the clinical team.

Aside from the absence of the person's legal guardian in service planning half the time, the next clinical team member left out of the service planning process most frequently was the person themselves. In 16 (12%) of the priority target cases reviewed, there was no evidence that the person participated in the planning of their services.

The review protocol also measured the involvement of other person's who may be needed as clinical team members but are not specifically required by Appendix C. These include, other V.O. clinical team members (e.g. substance abuse specialists, housing specialists, etc.), other state agencies involved with the person, other community mental health provider staff and any family member /designated representative of the class member. The involvement in service planning and service delivery of these other clinical team members (if needed based on the person's unique circumstances) was found as follows: other V.O. clinical team members were involved sixty-eight percent (68%) of the time; other state agencies involved with the person - eighteen percent (18%) of the time; community mental health provider – thirty-two percent (32%); and family member /designated representative – twenty-seven percent (27%) of the time.

Overall, compliance with this item increased 17% from that found in the 2005 Audit. Additionally, Appendix C findings for this audit met the requirements required in the Stipulation on Completion Dates ordered by the Court on May 23rd, 2006.

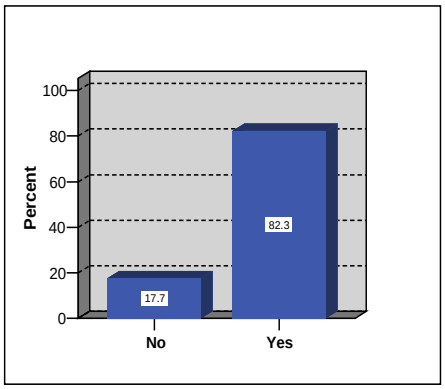
Appendix C, Criterion 3: *Within ninety days of a determination of eligibility, priority clients whose clinical needs required extended ISP's have extended ISP's, with a functional assessment and long-term view.* One (1) "priority target-site" class member had been enrolled less than ninety days and therefore this item was not applicable to him/her. Of the 139 class members reviewed, forty-eight (48) were found to have ISPs that met the agreed upon standards, resulting in 35% compliance. Fourteen (14) class members in this group did not have a current ISP.



Of the 125 ISPs completed, each required component of the long-term view (living situation, work/meaningful day, and social/community integration) was found to meet the standard of eighty percent (80%) or higher. The functional assessments however presented a larger challenge to the clinical teams. The assessment of the class members living status, skills and supports needed met the agreed upon standards 67% of the time, work/meaningful day status, skills and supports needed 60% of the time, and social/community integration status, skills and supports needed, 58% of the time.

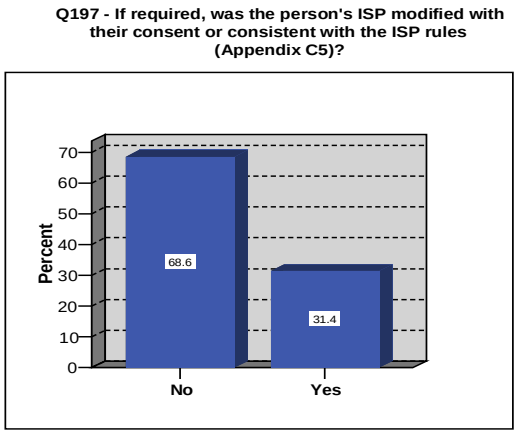
In addition to the long-term view and functional assessment, the ISP needs to contain individualized goals or objectives, specific steps/methods that describe how the goal will be achieved, have professional input into its development, and address all areas of need for the person. Eighty-six percent (86%) of the ISPs reviewed had individualized goals or objectives. Seventy-five percent (75%) had specific steps/methods describing how the goal will be achieved. There was evidence of professional input into the ISP 87% of the time, however, only 48% of the ISPs reviewed addressed all of the person's needs, especially all the needs identified in the Comprehensive Assessment.

Overall, the data for Appendix C 3. represents a decrease of 9% from the data found in the 2005 Audit. Additionally, the Stipulation on Completion Dates ordered by the Court on May 23rd, 2006 requires this item to be at a compliance level of 70%; while the actual findings for the 2006 Audit is at 35% level of compliance.



Appendix C, Criterion 4: *Priority clients shall have periodic reviews at least every six months.* Of the current ISPs reviewed for this group of class members, 82% (eighty-two percent) had been reviewed in the past six months. While on the surface it appears that class members ISP's are generally being reviewed every six months it should be noted that many of these reviews were superficial and were considered in compliance based on a brief staffing note that was found in the person's record. It was also found however, that while this time-based review of the ISP is generally being conducted; only 43% of the ISPs had been revised based on progress, lack of progress, and/or a change in the person's behavioral health needs. Additionally, in the interviews with the consumers, most of them were not involved in these reviews or did not remember they had taken place. The most important thing to note is these reviews were somewhat superficial and rarely resulted in any changes to the current ISP, even when they were found to be needed.

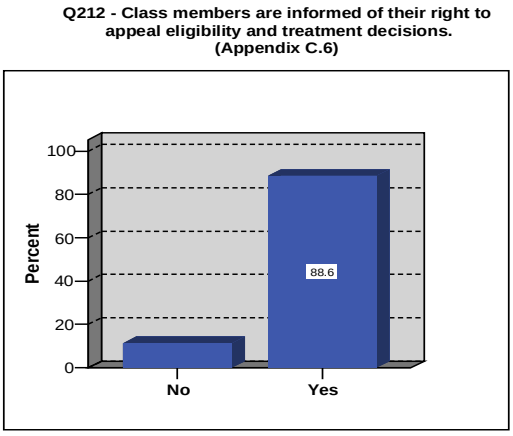
In some cases, there were multiple (4 or more) ISP's completed within the past 12 months that were exact duplicates of each other. The only variation found in these documents was different signature dates for the person and clinical team members. It is not clear why staff would "create" so much additional work by completing the same ISP over and over when it is not required. Overall, these findings represent a decrease of 11% from the data found in the 2005 Audit.



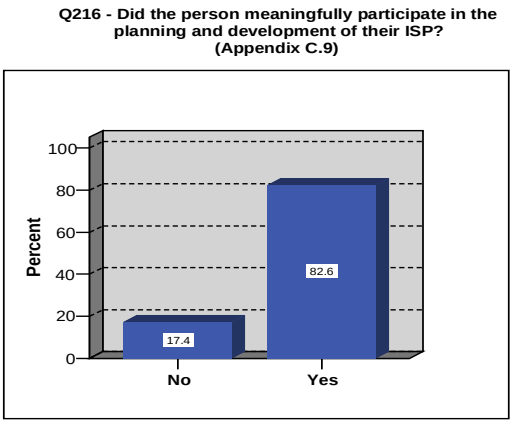
Appendix C, Criterion 5: *Whenever there is a substantial reduction of services, a substantial*

modification of a residential setting or day/vocational program or a termination of services, class member's ISPs are modified with the clients consent or consistent with the ISP rules. Thirty-six (36) of the "priority-target site" class members (26%) had a substantial change in services in the past year. Of these, one (1) situation was considered not applicable because the change had occurred less than thirty days from the date of the review. For the other thirty-five (35), it was found that the ISP had been appropriately modified for only thirty-one percent (31%), or eleven (11) class members. The results for this Appendix C5 correlate the findings found above for Appendix C4. Overall, this data represents a 10% decrease in compliance from the data found in the 2005 Audit.

Appendix C, Criterion 6: *Class members are informed of their rights to appeal eligibility and treatment decision.* One hundred twenty-four (124) "priority-target site" class members (89%) were found to have been informed of their right to appeal eligibility and treatment decisions. This determination was based on whether the person had signed the required documents or had verbally revealed that they understood the grievance process. Overall, this data represents a 13% increase in compliance from the data found in the 2005 Audit.

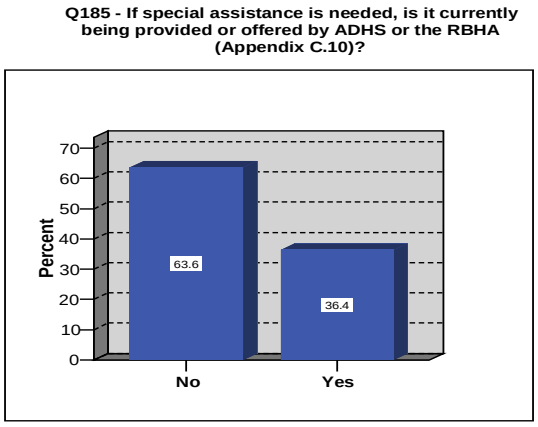


Appendix C, Criterion 9: *Class members participate in the planning and development of their ISP if one exists, their treatment plan if no ISP is available, or the Special Needs Treatment Plan for inmates of the jail.* This criterion was measured using the responses to interviews conducted and by reviewing documentation in the clinical record. For example, persons reviewed were asked whether they knew what was stated on their ISP, whether choices and options for services were explained to them and



whether they were provided opportunities for input into their ISP goals and services. This criterion was not applicable for only one "priority-target site" class member who had been in services less than 90 days. Of the 139 class members for whom this criterion was applicable, 114 (83%) were found to have participated in the planning and development of their ISP. Overall, this data represents an increase of 17% from the 2005 Audit findings. The Stipulation on Completion Dates ordered by the Court on May 23, 2006 is completely met for Appendix C 9.

Appendix C, Criterion 10: *Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RHBA in the ISP and grievance process.* This criterion is evaluated through three questions:



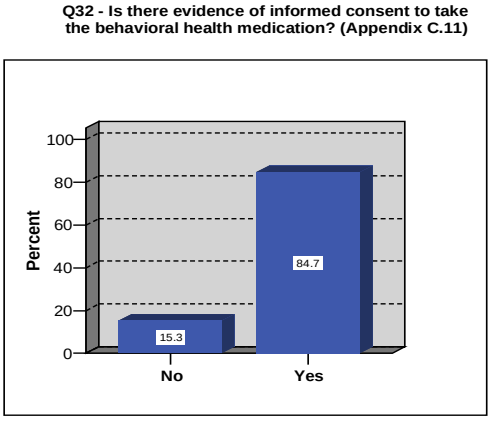
- Did the clinical team assess whether the person needed special assistance in the ISP and grievance process?
- Regardless of the team assessment/decision, is there evidence that the individual requires special assistance?
- If special assistance was needed, was it provided by ADHS or the RBHA?

For the first item, 128 (91%) of the “priority target-site” class members had been assessed by the team for the need for special assistance. Twenty-three class members (17%) were found to need special assistance due to physical or cognitive deficits, or language difficulties that interfere with the person’s ability to communicate effectively. Of these twenty-three individuals, only eight (36%) were found to be receiving the special assistance needed to participate in the ISP and grievance process. The majority of the person's determined to need special assistance, 64% were not receiving it at the time of the review. The primary reasons that theses individuals needed special assistance were that the person was unable to communicate choices, desires and

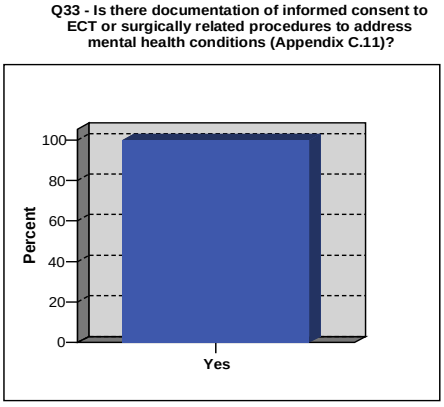
preferences and needed assistance in the service planning process. Overall, this data represents an increase of 8% in compliance with this item when compared to the findings of the 2005 Audit.

Appendix C, Criterion 11: *Class members' charts show documentation of adequate informed consent to medication, ECT, and surgically related procedures to address mental health conditions.* This criterion was measured through three questions:

- Is the person currently prescribed behavioral health medication?
- Is there evidence that the person/guardian provided verbal or written consent to take the psychiatric medication?
- Is there documentation of adequate informed consent to ECT or surgically related procedures to address mental health conditions?



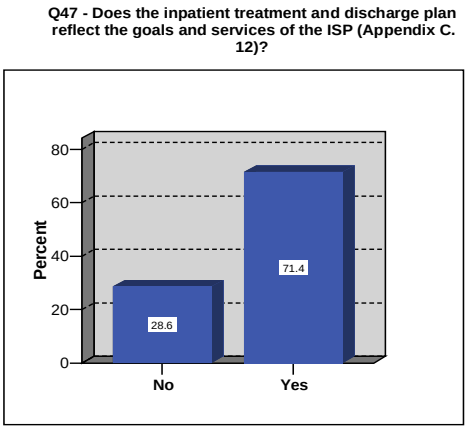
One hundred thirty-one (131) "priority target-site" class members (94%) were being prescribed behavioral health medications through the RHBA. Of these 131 class members, evidence of verbal or written consent to take the medications was found for 85%, or 111 individuals. Overall, this represents an increase of 14% from the 2005 Audit findings for this same item.



Two class members in this group had undergone ECT in the past year and informed consent for this procedure was found for both. It should be noted that these ECT treatments were initiated and provided by a private local hospital and not the RHBA.

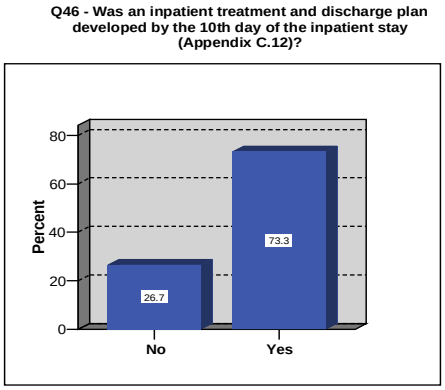
Appendix C, Criterion 12: *Class members, if still remaining for more than seven days in an inpatient treatment setting, have an ITDP by the tenth*

day, which is derived from their ISP, or from the treatment plan if one exists. Three questions addressed this criterion:

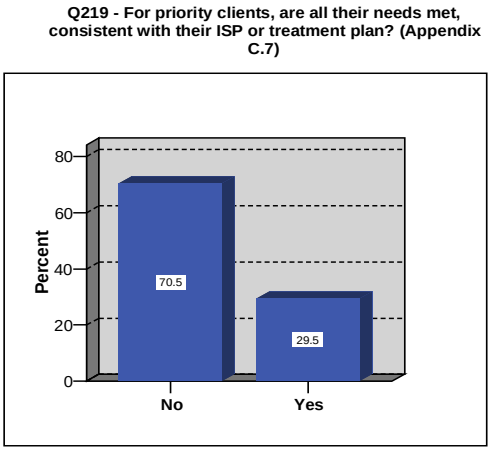


- Has the person had an inpatient admission within the last 12 months?
- Was an inpatient treatment and discharge plan developed by the 10th day of the inpatient stay?
- Does the inpatient treatment and discharge plan reflect the goals and services of the ISP?

Twenty-eight individuals, of the 140 "priority target-site" class members, had an inpatient admission in the past year. However, only 15 individuals (54%) had admissions that lasted longer than 7 days. Of these 15 class members, eleven (11) had ITDPs developed by the 10th day of admission (73%). One person did not yet have an ISP because referral to services occurred as a result of the hospital admission. Of the remaining 14 class members, ten (10) of the ITDPs (71%) reflected the goals and services of the ISP. Overall, these findings represent a 14% increase in compliance from the findings of the 2005 Audit.



***Appendix C, Criterion 7**: The needs of priority class members are met consistent with their ISP.* This criterion requires that each priority class member has his/her behavioral health needs met in three life areas (living, working/meaningful day, social/community integration) and the ISP must reflect the services and supports needed in each of these life areas.

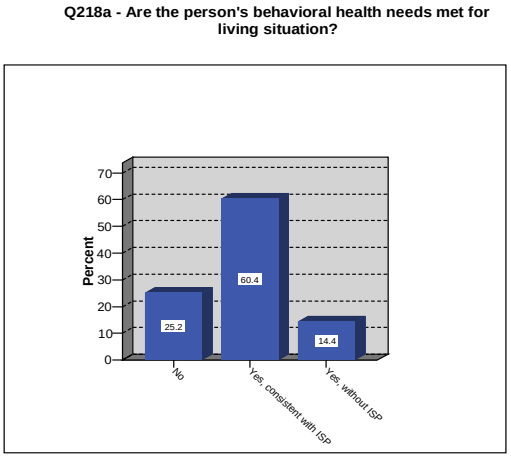


This item was not applicable to one of the "priority target-site" class members because the person had been enrolled in service less than ninety days. Of the 139 class members for whom this item was applicable, forty-one (41) were found to have their behavioral health needs met consistent with their ISP, resulting in 30% compliance. Overall, these findings are only 2% less than those found in the 2005 Audit.

Additionally, the Stipulation on Completion Dates ordered by the Court on May 23, 2006 requires a compliance level of 55%. It is important to note that in order to fully understand this finding, the compliance ratings in the individual life areas need to be reviewed closely. Upon reviewing the sub-items that "roll up" into the final score, the data represents additional important facts that become an integral part of the issue in determining if consumers' needs are being met.

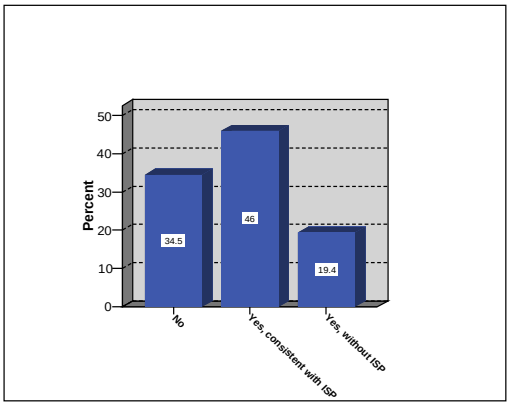
In the area of living, 84 (60%) class members had their living needs met consistent with their ISP. In the area of working/meaningful day, 56 (40%) class members had their needs met consistent with their ISP. In the area of social/community integration, 64 (46%) class members had their needs met consistent with the ISP. As reflected in the charts, a smaller number of class members had their needs met without the ISP. This means that the person was receiving the needed services and supports but they were not written in the person's ISP. During the past year there has been a high turn over among case managers. For 60% of the consumer's reviewed, they had been assigned to a case manager in most cases for less than 6 months. The need for including pertinent information regarding the person's situation in the ISP becomes extremely important especially given this rate of turn over.

When the actual service provision arrangements are not written in the ISP, the person is at more risk of losing the service when they are re-assigned to a new case manager.

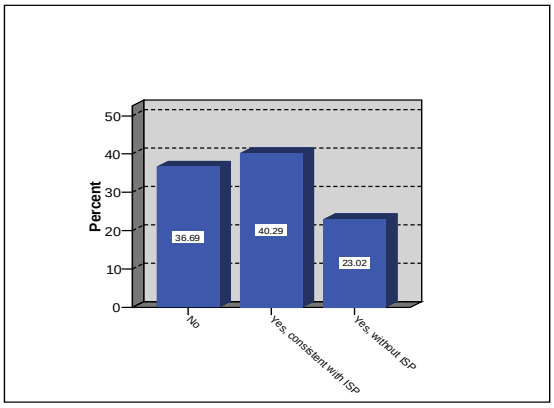


Additionally, the data shows that there is a direct correlation between "needs met without ISP" with other data found that demonstrates poor quality of care for a number of other criterion accessed during this audit. This data will be discussed more fully in the Summary Section of this report.

Q218c - Are the person behavioral health needs met social / community integration?

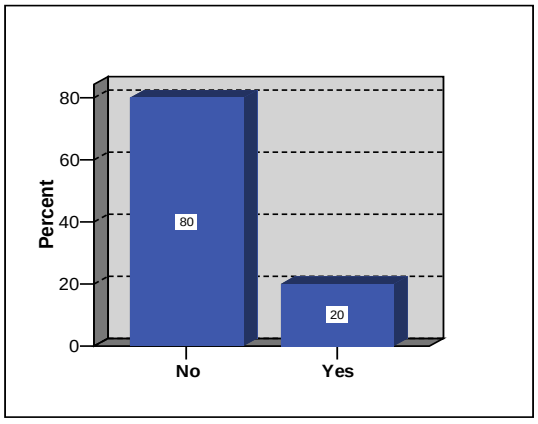


Q218b - Are the person's behavioral health needs met for meaningful day / work situation?

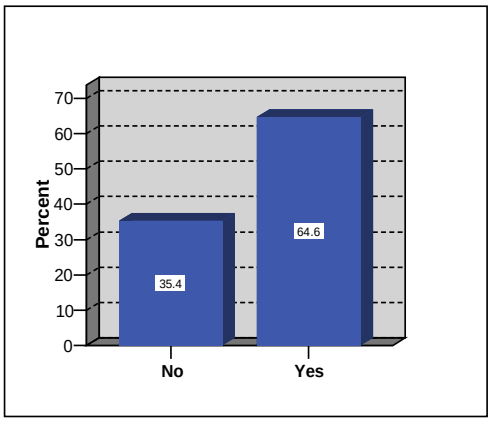


Finally, employment is a valuable component of rehabilitation and recovery. Work provides structure and promotes a positive feeling of self -worth and is a key factor in an individual's movement towards recovery. The results of the review found that 27 individuals were working full or part-time (20%), while 108 individuals were not employed in any capacity (80%). Overall, this is an increase of 12% compared to the findings of the 2005 Audit.

Q207 - Is the person employed?



Q34 - Is there evidence of coordination of care with the primary care physician?

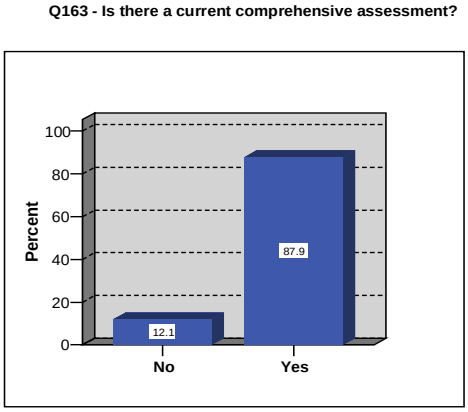


Supplemental Agreement Data

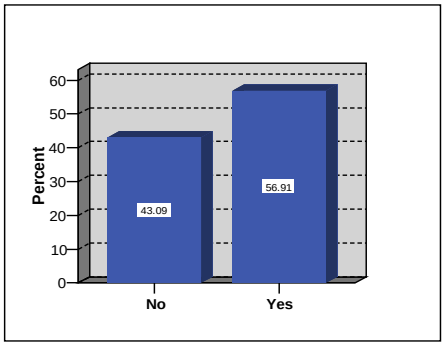
1. Coordination of Care with PCP. The item was not applicable to ten (10) "priority target-site" class members. Nine class members were not prescribed

behavioral health medications by the RHBA and one person had been enrolled less than ninety days. Of the 130 individuals for whom this was applicable, eighty-four (84) were found to have their behavioral health care coordinated with their PCP (65%). This finding is consistent with the finding that 65% of the class members in the group were found to have their physical health related issues and needs addressed overall. Overall, these findings represent an increase of 5% in compliance from the data noted in the 2005 Audit.

2. Comprehensive Assessment completeness, relevance and timeliness. Nineteen items comprising three questions in the protocol addressed the comprehensive assessment:



- Is the comprehensive assessment current?
- Does it include the following components: mental health status, legal status and apparent capacity, living environment, interpersonal and social skills, social setting, physical health status, level of daily living skills, criminal justice history, developmental history, employment or vocational training, education, language abilities, public and private resources/entitlements, substance use history, risk assessment, sexual behavior/sexual abuse, and recommendations/next steps.

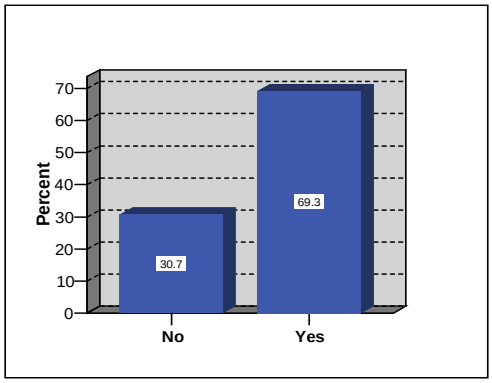


- Is the comprehensive assessment complete?

One hundred and twenty-three (123) of the 140 "priority target-site" class members had a current comprehensive assessment (88%). Overall, these findings represent a 10% decrease in compliance compared to the findings of the 2005 Audit.

Of these, seventy (70) of the assessments were found to be complete (57%) in that the assessment addressed all applicable areas listed in the second bullet above. It should be noted that some areas could be not applicable depending on the person's unique circumstances.

All but four of the listed areas were found to be addressed in the comprehensive assessment at least 80% of the time, just not always at the same time. The four areas most often absent or not reasonably addressed in the comprehensive assessment are criminal justice history; developmental history (applicable to 22 individuals); substance use history and behavior/sexual abuse (applicable to 34 individuals). Overall, these findings are exactly at the same level of compliance to those found in the 2005 Audit.



3. The case manager/clinical team's involvement in the day-to-day monitoring of the status of the class member and whether or not the recommended services are being delivered. Five items in the protocol address this issue:

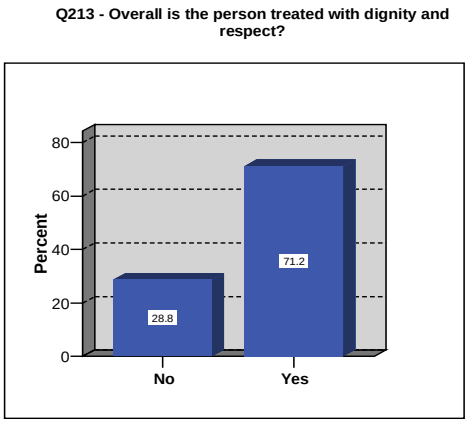
- Does the case manager/clinical team respond to changes in the person's treatment needs and/or life circumstances in a timely manner?
- Does the person receive the level of case management they need?

- Is there evidence of communication between the person and each of the clinical team members?
- Does the clinical team assure that all services are in place in accordance with the ISP?
- Does the case manager/clinical team monitor the services the provided?

It was found that the case manager/clinical team provided a timely response to changes in the person's treatment needs and/or life circumstances for sixty percent (60%) of the "priority target-site" class members reviewed. Sixty-nine percent (69%) of the class members in this group were

found to be receiving the level of case management needed. This represents 17% improvement from the data found in the 2005 Audit. This improvement can be directly related to the increase of additional Assertive Treatment Teams at the targeted-sites. This also supports that improvement can be demonstrated when ADHS/DBHS implements the requirements in the Case Management Plan.

Evidence of communication between the person and each of his/her clinical team members was found for seventy-nine percent (79%) of those reviewed in this group. Sixty percent (60%) of this group were found to have clinical teams assuring that all services are in place in accordance with the ISP and seventy-three percent (73%) were found to have their services monitored by the case manager/clinical team.



4. The class member is treated with dignity and respect by the case management agency, provider and any other involved individual. This determination is based on consideration of the following factors:

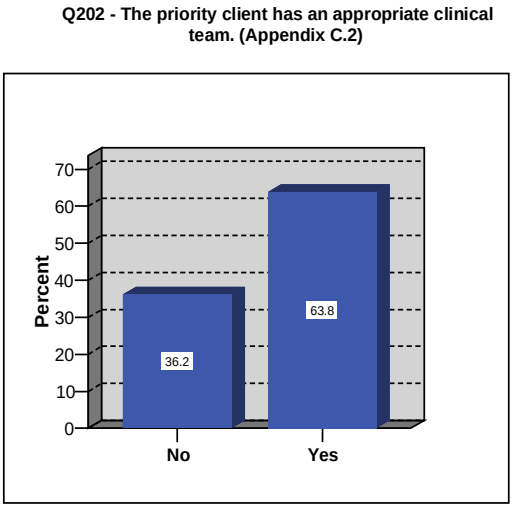
- Indication that the person is treated as a unique and valued individual (such as calls returned in a timely manner, etc.)
- Individual's rights are honored and protected (such as being given information, having a current ISP, etc.)
- Provision of special assistance, when applicable
- Person's input, preferences, choices and personal goals are included in the ISP process and their participation encouraged in the process (such as individualized goals and multiple attempts made to engage the person)
- Changes in the person's circumstances are responded to by the clinical team (such as timeliness of service provision and ISP revised when new or emerging needs develop)
- Ethnic and cultural differences are recognized and respected by the clinical team (inquiring about cultural preferences and incorporating these into the person's service provision
- All information gathered from all of the interviews conducted during the audit.

Of the class members reviewed, ninety-nine (99) were found to be treated with dignity and respect (71%). Items related to this determination that have not been previously cited in this report include evidence that the clinical team offered various treatment options for the person to choose from and whether the clinical team continually made efforts to engage the person in rehabilitation, treatment and support services. Seventy-eight percent (78%) of the class members

in this group were found to have been provided a variety of treatment options. Sixty-seven percent (67%) of the class members were found to have clinical teams that made continuous efforts to engage the person in services.

Priority Class Members Non Target Sites

Appendix C Data



Appendix C, Criterion 2: *Except in the unusual circumstance where the person is properly assigned to the case coordination model, priority clients have a clinical team which includes the client, nurse, physician, case manager and vocational specialist unless employment has been determined by the team and the client to no longer be an issue.* The composition of the clinical team is critical to assure that class members' needs are identified, planned and provided for. The results of the review demonstrated that ninety (90) of the 141 "priority non-target site" class members (64%) had an appropriately constituted clinical team. This finding is due primarily to the fact that only two (2) of five legal guardians (40%) and 109 (77%) of class members were involved in service plan development and service delivery. In addition, the expertise of a vocational specialist was required for 118 class members but evident 75% of the time. Those class members who did not have the benefit of a vocational specialist on their team either told the reviewer that they were interested in working or were determined by the reviewer to have no meaningful activity during the day. A rehabilitation specialist was considered to meet the requirement of a vocational specialist if it could be determined that this clinical team member was assisting the class member in working toward a learning/working/meaningful day goal. Other required clinical team

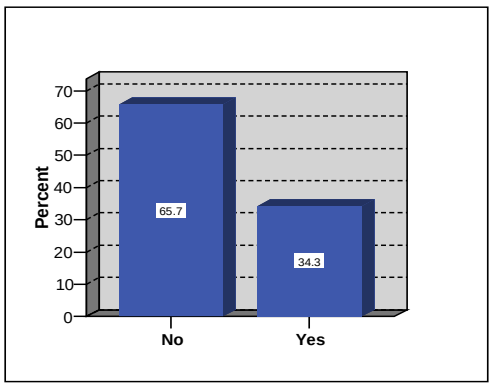
members (e.g. the physician, nurse and case manager) were involved in service planning and delivery more than 80% of the time.

While not a requirement of Appendix C, the review protocol also measured the involvement of other clinical experts (e.g. housing and substance abuse specialists), other state agencies involved with the person (e.g. adult probation, DES/Division of Developmental Disabilities, etc.), community provider agency staff and family members/designated representatives. The findings show that clinical specialists/experts were involved sixty-one (61%) of the time; other state agency staff involved with the person – twenty-three percent (23%) of the time; community mental health provider staff – nineteen percent (19%) of the time, and; family members/designated representatives –twenty percent (20%) of the time.

Overall, compliance with this item increased 20% from that found in the 2005 Audit.

Appendix C, Criterion 3: *Within ninety days of a determination of eligibility, priority clients whose clinical needs required extended ISP's have extended ISP's, with a functional assessment and long-term view.* To be determined in full compliance, the ISP must be current, contain goals, steps and methods for service delivery, evidence of professional input and include a functional assessment that addresses the person's status, skills and supports needed to achieve their long term goals.

Of the 140 "priority non-target class members" reviewed, forty-eight (48) were found to have ISPs with a functional assessment and a long term view, resulting in 34% compliance. To count an ISP current, the ADHS Office of Behavioral Health Licensure requires the signature of the client (class member) and at least one other member of the clinical team. Using this definition, it could be determined that thirty (30) class members in this group (22%) did not have a



current ISP. One (1) class member was enrolled less than ninety days. Therefore, this item was not applicable.

For the 109 class members who had a current ISP (78%), at least eighty percent (80%) of the time, each required component of the long-term view (living situation, work/meaningful day, and social community integration) was complete. However, the functional assessment presented a larger challenge to the clinical team. For example, the functional assessment accurately reflected the class member's living situation and the skills and supports they required in this area only 63% of the time. In the area of work/meaningful day, the functional assessment was determined to be in compliance for 65% of class members. In the area of social/community integration, the functional assessment reflected the class member's status, skills and supports required 68% of the time. These findings also reflect the fact that only 49% of the ISPs addressed all of the person's needs. Needs absent in the ISP include class members who are on probation, court ordered treatment or efforts planned to engage the person to accept services to address their needs (e.g. outreach and/or showing the person available service options, etc.).

Eighty-six percent (86%) of the ISPs reviewed contained individualized goals or objectives for addressing the needs that were identified on the service plan. Seventy-six percent (76%) included specific steps/methods describing how the goals and objectives would be achieved. While the data showed that there was professional input into the ISP by members of the clinical team (e.g. physician, RN, case manager, etc.) occurred 87% of the time, it was evident that limited participation from community provider agency staff (including, but not limited to, inpatient staff) other state agencies familiar with the person and family members/designated representatives negatively impacted the relevance and quality of the ISP (e.g. class members' needs identified and addressed only 49% of the time).

Overall, the data for Appendix C 3 represents a decrease of 27% from the data found in the 2005 Audit.

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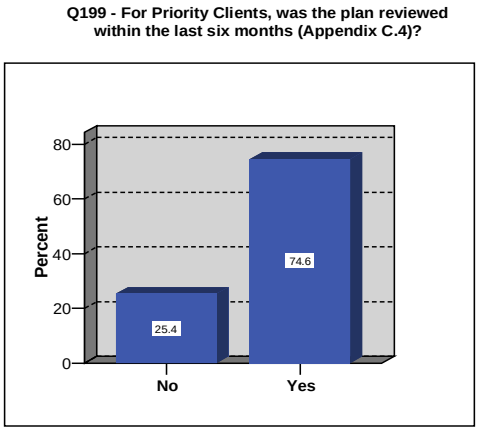
Appendix C, Criterion 4: *Priority clients shall have periodic reviews at least every six months.*

The ISP is the roadmap for delivering services. It is developed based on a comprehensive assessment of the person's status and needs and is reviewed and updated as needed when additional information/input is gained during the course of treatment. A current and complete ISP assures that class members and clinical staff understand their role and responsibilities in receiving or providing care and that, as the person's needs change so does their ISP. The periodic review and modification to the ISP assures that as staff change, the direction of treatment remains on course.



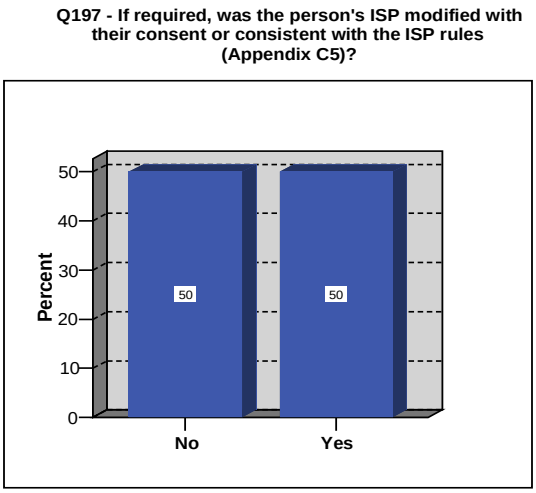
Of the 134 "priority non-target site" class members for which this criterion applied, 100 (75%) had their ISP reviewed within the past six months. Two class members were enrolled less then 90 days and five class members had their initial ISP developed within the past six months. Therefore, this criterion did not apply.

The most important thing to note is that only 35% of ISPs were revised based on the person's progress, lack of progress and/or a change in the person's behavioral health needs. This indicates that ISPs are reviewed to meet the standard, but that when necessary, they were not updated for two-thirds of class members.

In some cases there were multiple (4 or more) ISPs completed within the past 12 months that were exact duplicates of each other. The only variation observed in these documents was that different signature dates of the person and clinical team members. It is not clear why staff would "create" so much additional work by completing multiple ISPs when not required.

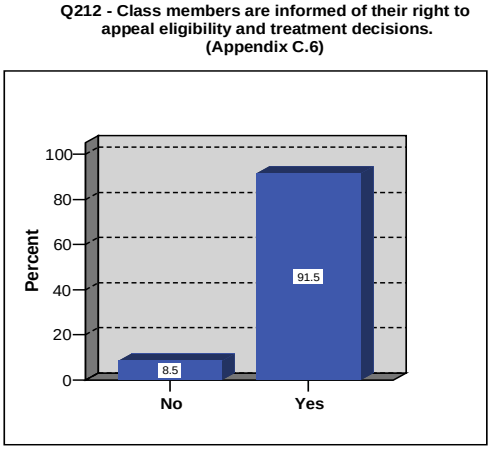
Overall, these findings represent a decrease of 15% from the data found in the 2005 Audit.

Appendix C, Criterion 5: *Whenever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program or a termination of services, class member's ISPs are modified with the clients consent or consistent with the ISP rules.* Thirty-three (33) of the "priority non-target site" class members (24%) had a substantial change in services in the past year. Of these, three (3) situations were considered not applicable because the person had initiated or consented to the change. For the other thirty (30), it was found that the ISP had been modified for fifty percent (50%), or fifteen (15) class members. These findings are consistent with those for Appendix C, Criterion 4, that require the ISP to be revised based on the person's progress, lack of progress or a change in the person's behavioral health needs.



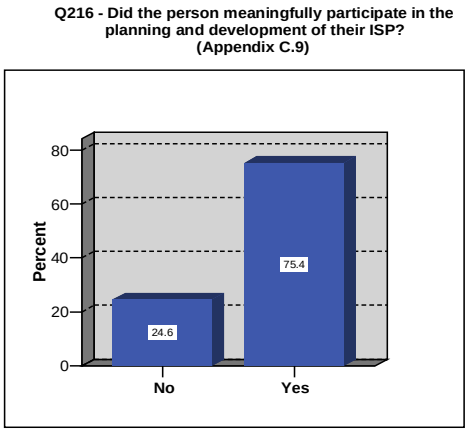
Overall, this data represents a 19% increase in compliance from data found in the 2005 Audit.

Appendix C, Criterion 6: *Class members are informed of their rights to appeal eligibility and treatment decision.* One hundred twenty-nine of 140 "priority non-target site" class members (92%) were found to have been informed of their right to appeal eligibility and treatment decisions. This determination was based on whether the person had signed the required documents or had verbally revealed that they understood the grievance process.



Overall, this data represents a 20% increase in compliance with C 6 from the data found in the 2005 Audit.

Appendix C, Criterion 9: *Class members participate in the planning and development of their ISP if one exists, their treatment plan if no ISP is available, or the Special Needs Treatment Plan for inmates of the jail.* This criterion could not be determined for two "priority non-target site" class members due to conflicting available information. Of the 138 class members for whom this criterion could be determined, 104 (75%) were found to have participated in the planning and development of their ISP. This finding is not consistent with earlier data that showed that only 49% of ISPs contained all of the class members needs. This may indicate that ISP discussions with class members are superficial and/or that class members have minimal expectations relative to what the behavioral health system can provide. Additionally, many class members expressed frustration with continued turnover in their clinical team, primarily in the area of case management. These issues along with the finding that there was poor representation of community provider agency staff, other state agencies and family members/designated representatives in service planning and development resulted in only one-half of the ISPs for class members in this group reflecting the needs and services required by the person.



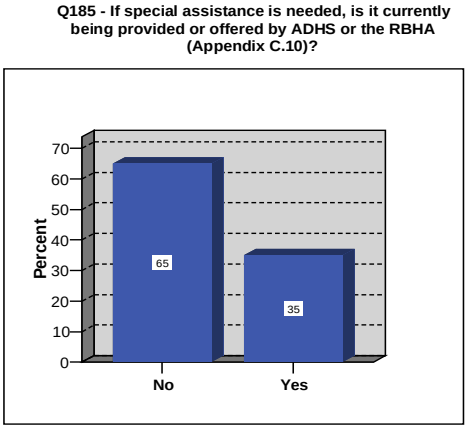
Overall, this data represents an increase of 9% from the 2005 Audit.

Appendix C, Criterion 10: *Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RHBA in the ISP and grievance process.* This criterion is evaluated through three questions:

- Did the clinical team assess whether the person needed special assistance in the ISP and grievance process?

- Regardless of the team assessment/decision, is there evidence that the individual requires special assistance?

- If special assistance was needed, was it provided by ADHA or the RBHA?

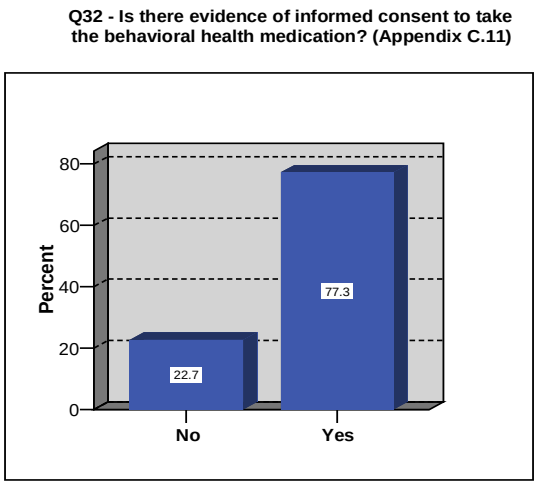


For the first question, 122 (87%) of the "priority non-target site" class members had been assessed by the team for the need for special assistance. Twenty (20) class members (14%) were found to need special assistance due to physical or cognitive deficits, or language difficulties that interfere with the person's ability to communicate effectively. Of these twenty individuals, seven (35%) were found to be receiving the special assistance needed to participate in the ISP and grievance process.

In some cases, class members who needed special assistance were appropriately referred to the ADHS Office of Human Rights and were assigned an advocate who never participated in the development of the person's ISP.

Overall, this data represents a slight decrease of 3% compliance when compared to the 2005 Audit.

Appendix C, Criterion 11: *Class members' charts show documentation of adequate informed consent to medication, ECT, and surgically related procedures to address mental health conditions. This criterion was measured through three questions:*



- Is the person currently prescribed behavioral health medication?

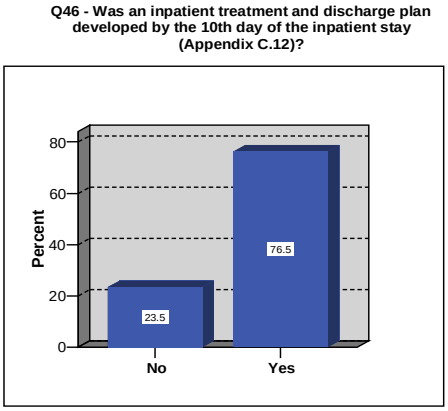
- Is there evidence that the person/guardian provided verbal or written consent to take the psychiatric medication?

- Is there documentation of adequate informed consent to ECT or surgically related procedures to address mental health conditions?

One hundred thirty-two (132) "priority non-target site" class members (94%) were currently prescribed behavioral health medications through the RBHA. Of these 132 class members, evidence of verbal or written consent to take the medication was found for 77%, or 102 individuals. Overall, this represents a decrease of 8% from the 2005 Audit findings for the same item. Typically, when evidence of informed consent could not be found, it was missing for some, but not all, of the behavioral health medication prescribed.

For some class members reviewed, the person's medication had run out but not formally discontinued and then prescribed again after the site was notified that the person was selected for the review.

None of the class members reviewed in this group had undergone ECT or surgically related procedures to address their mental health condition. Therefore, this did not factor into the compliance of this criterion.

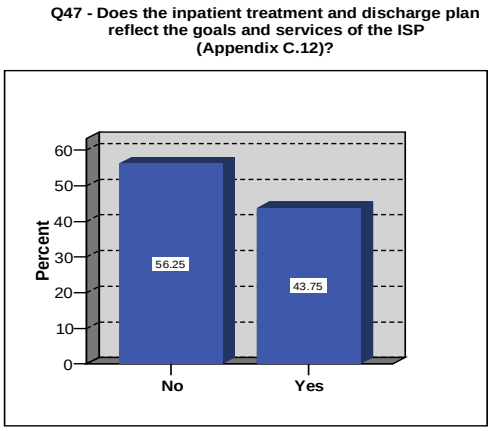


Appendix C, Criterion 12: *Class members, if still remaining for more than seven days in an inpatient treatment setting, have and ITDP by the tenth day, which is derived from their ISP, or from the treatment plan if one exists. Three questions addressed this criterion:*

- Has the person had an inpatient admission within the last 12 months?

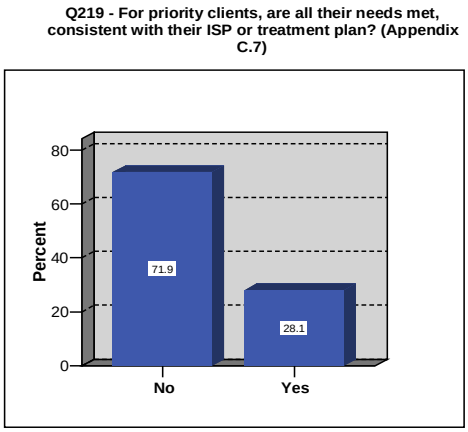
- Was an inpatient treatment and discharge plan developed by the 10th day of the inpatient stay?

- Does the inpatient treatment and discharge plan reflect the goals and services of the ISP?

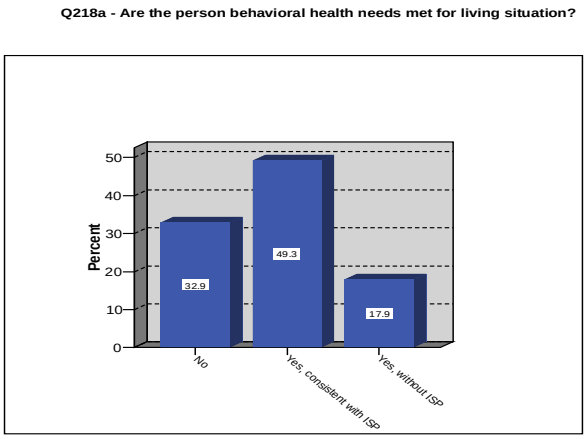


Twenty-two (22) of the 141 "priority non-target site" class members had an inpatient admission in the past year. However, only 17 individuals had admissions that lasted longer than 7 days. Of these 17 class members, thirteen (13) had an ITDP developed by the 10th day of admission (77%). This data represents a 24% increase from the 2005 Audit. Of these same 17 class members, one ITDP was not available for review. Of the remaining 16 ITDPs, seven (7), or 44%, reflected the goals and services of the ISP.

This finding is consistent with the data found for Appendix C, Criterion 4 and 5. When class members were admitted to the most intensive level of care (inpatient), the ISP and ITDP did not come together before the person's discharge. This data represents a decrease of 30% from the 2005 Audit.

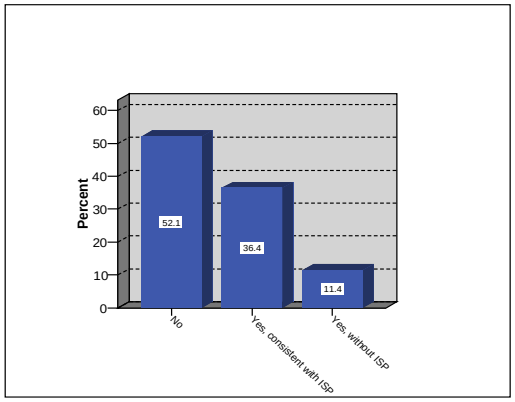


***Appendix C, Criterion 7**: The needs of priority class members are met consistent with their ISP.* This criterion requires that each priority class member has his/her behavioral health needs met in three life areas (living, working/meaningful day, social/community integration and the ISP must reflect the services and supports needed in each of these life areas. This item was not applicable to two of the "priority non-target site" class members because they had been enrolled in service less than ninety days. Of the 139 class members for whom this item was applicable, thirty-nine (39) were found to have their behavioral health needs met consistent with their ISP, resulting in 28% compliance. Overall, these findings represent a slight decrease of 2% from the results found in the 2005 Audit.



Upon reviewing the sub-items that "roll up" to the final score, this data represents additional important facts that become an issue in determining if consumers' needs are being met.

Q218b - Are the person behavioral health needs met meaningful day / work situation?

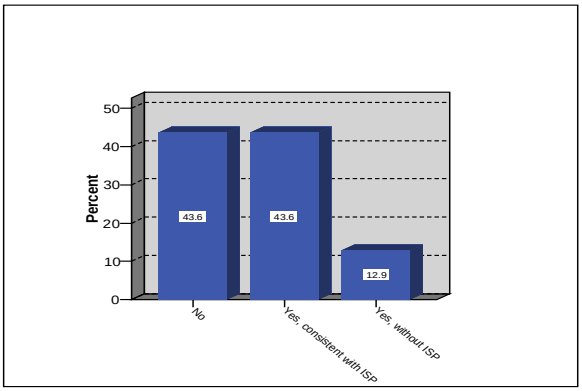


In the area of living, 69 (49%) class members had their needs met consistent with the ISP. In the area of working/meaningful day, 51 (36%) of class members had their needs met consistent with the ISP. In the area of social/community integration, 61 (44%) of class members had their needs met consistent with the ISP.

As reflected in these charts, a smaller number of class members had their needs met without the ISP. This means that the person was receiving the needed services and supports but that they were not written in the person's ISP.

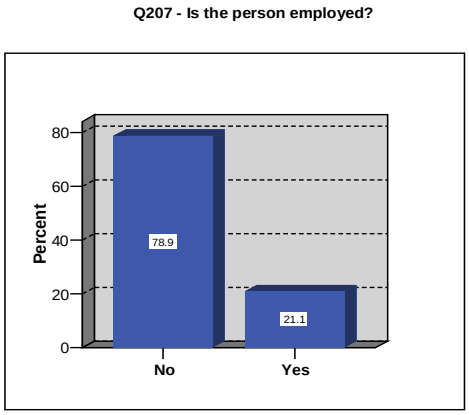
During the past year, there has been a high turnover among case managers. Fifty-five percent (55%) of class members reviewed had been assigned to a case manager for less than six months. The need for including pertinent information regarding the person's situation in the ISP becomes extremely important especially given this rate of change.

Q218c - Are the person behavioral health needs met social / community integration?



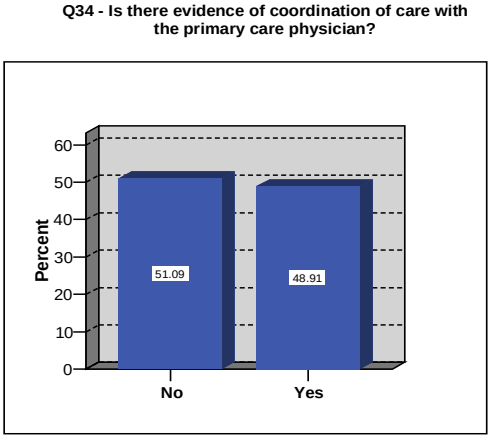
When actual service provision arrangements are not written in the ISP, the person is at more risk of losing the service when they are re-assigned to a new case manager. As stated previously, this item will be discussed more fully in the Summary Section of this report.

Finally, employment is a valuable component of rehabilitation and recovery. Work provides structure and promotes a positive feeling of self-worth and is a key factor in an individual's movement towards recovery. The results of the review found that 28 (21%) of this group of individuals were employed either full or part-time at the time of this review.



Priority Class Members Non Target Sites Supplemental Agreement Data

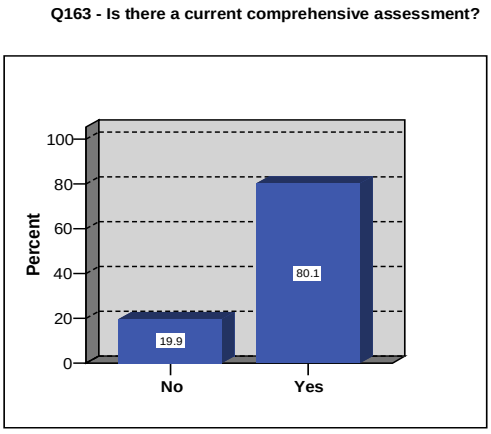
1. Coordination of Care with the Primary Care Physician (PCP): ADHS/DBHS policy requires that, at a minimum, the following information must be provided to the assigned PCP: the person's diagnosis; current prescribed behavioral health medication (including strength and dosage), and any other events requiring medical consultation with the person's PCP. Of the 137 "priority non-target site" class members to whom this requirement applied, documentation could be found for sixty-seven (67) class members that this information was provided to the assigned PCP (49%). Two class members were not assigned to a PCP and two had been enrolled less than ninety days. Therefore, the requirement did not apply. Overall, this represents a slight decrease of 2% in the results found in the 2005 Audit.



To determine if clinical teams were coordinating care with the PCP and assisting class members in receiving needed health care, reviewers were asked to determine whether the person's physical health related issues and needs were being addressed. Sixty-two percent (62%) of "priority non-target site" class members were found to have their physical health related issues and needs addressed. Overall, this data represents an increase of 8% from the 2005 Audit.

2. Comprehensive Assessment completeness, relevance and timeliness. Nineteen items comprising three questions in the protocol addressed the comprehensive assessment:

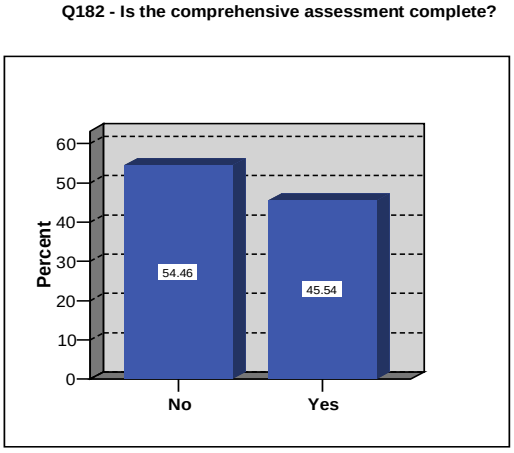
- Is the comprehensive assessment current?



- Does it include the following components: mental health status, legal status and apparent capacity, living environment, interpersonal and social skills, social setting, physical health status, level of daily living skills, criminal justice history, developmental history, employment or vocational training, education, language abilities, public and private resources/entitlements, substance use history, risk assessment, sexual behavior/sexual abuse, and recommendations/next steps.

- Is the comprehensive assessment complete?

The Comprehensive Assessment is developed within ninety days of the person's initial enrollment and updated at least annually or more often as needed to reflect significant changes in the person's life. The Comprehensive Assessment forms the basis of the ISP. That is, the person's status and preferences are used to identify the needs and services that will be planned for in the ISP. If relevant information is not gathered during the assessment, it is not typically translated into the ISP.



Not all required areas noted above apply to every class member. For example, criminal justice history, substance use history and developmental history were not relevant issues for all class members. Therefore, if not applicable, the information is not included in the data.

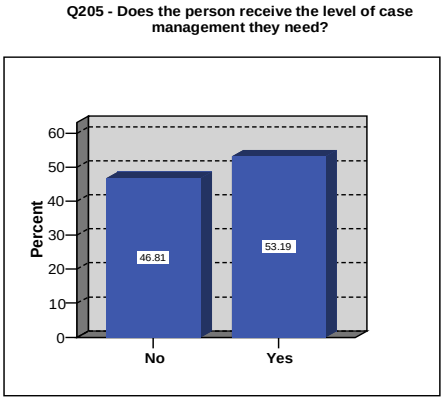
One hundred and thirteen (113) of the 141 "priority non-target site" class members had a current comprehensive assessment (80%). Overall, these findings represent a 14% compliance decrease with the findings of the 2005 Audit. Of those class members who had a current comprehensive assessment, only fifty-one (51) of the assessments were accurate and reasonably addressed all the required/applicable components listed above (45%). Overall, this finding represents a decrease of 6% found in the 2005 Audit. This finding is somewhat surprising in that reviewers were instructed to factor any updated progress information contained in the clinical record into their rating even if this information was not included on the "supplemental" form specifically created by ADHS/DBHS for this purpose. However, this result is consistent with the data reported for Appendix C, Criterion 3 which showed that only 49% of ISPs addressed all of the person's needs.

There were seven required components that were not addressed in the assessment when necessary. These areas were: interpersonal and social skills; physical health status; criminal justice history (if applicable); developmental history (if applicable); employment/vocational training; substance use history (if applicable), and; sexual behavior/sexual abuse (if applicable).

It is also extremely important to note that to develop a reasonably complete Comprehensive Assessment clinical staff must know the person and engage them and others involved in their life (e.g. legal guardians, community provider staff, other state agencies, family members/designated representatives). For 31% of cases reviewed, the reviewer found no evidence that a face-to-face meeting was conducted with the person to complete the assessment. Forty-nine percent (49%) of class members had been assigned to their psychiatrist/nurse practitioner/physician assistant for six months or less. Fifty-five percent (55%) of class members in this group had been assigned to their case manager for six months or less.

3. The case manager/clinical team's involvement in the day-to-day monitoring of the status of the class member and whether or not the recommended services are being delivered. Five items in the protocol address this issue:

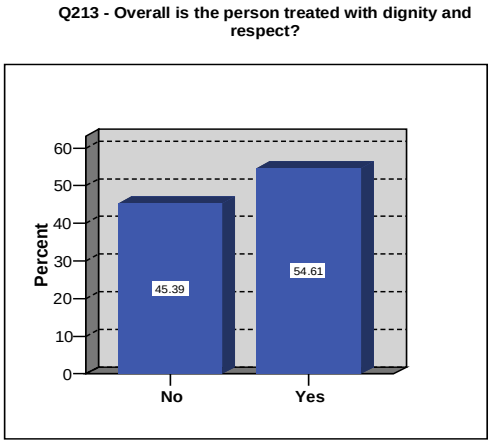
- Does the case manager/clinical team respond to changes in the person's treatment needs and/or life circumstances in a timely manner?
- Does the person receive the level of case management they need?
- Is there evidence of communication between the person and each of the clinical team members?
- Does the case manager/clinical team assure that all services are in place in accordance with the ISP?
- Does the case manager/clinical team monitor the services provided?



It was found that the case manager/clinical team provided a timely response to changes in the person's treatment needs and/or life circumstances for fifty-eight (58%) of "priority non-target site" class members reviewed. Fifty-three percent (53%) of the class members in this group were found to be receiving the level of case management needed. This finding is consistent with data collected on caseload size. Sixty-one percent (61%) of class members were assigned to a case manager who had a caseload of 31 or above. Of these, 19% of the caseloads were 41 or above.

Communication between the person and each of his/her clinical team members was found for sixty-four (64%) of those reviewed in this group. Clinical teams/case managers for fifty-three percent (53%) of class members assure that all services included on the ISP are in place. In a larger percentage of cases, (66%), the case manager/clinical team monitored the services on the ISP that were delivered.

When compared to the results of the 2005 Audit, there is an increase of 10% in the timely response to changes in the person's treatment needs by the clinical team. The data also shows an increase of 17% in the clinical team assuring that all services in the ISP are in place and an increase of 25% in the monitoring of services included in the ISP.



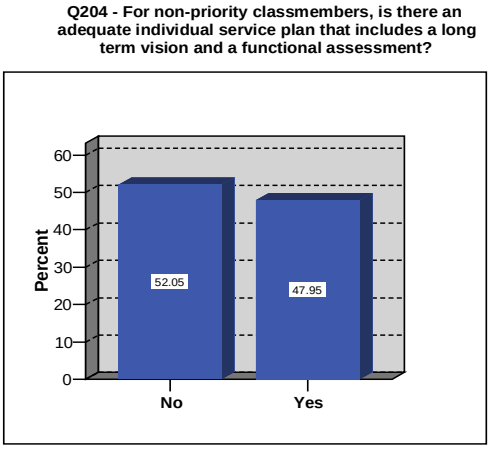
4. The class member is treated with dignity and respect by the case management agency, provider and any other involved individual. This determination is based on consideration of the following factors:

- Indication that the person is treated as a unique and valued individual (such as calls returned in a timely manner, etc.)
- Individual's rights are honored and protected (such as being given information, having a current ISP, etc.)
- Provision of special assistance, when applicable
- Person's input, preferences, choices and personal goals are included in the ISP process and their participation encouraged in the process (such as individualized goals and multiple attempts made to engage the person)
- Changes in the person's circumstances are responded to by the clinical team (such as timeliness of service provision and ISP revised when new or emerging needs develop)
- Ethnic and cultural differences are recognized and respected by the clinical team (inquiring about cultural preferences and incorporating these into the person's service provision
- All information gathered from all of the interviews conducted during the audit.

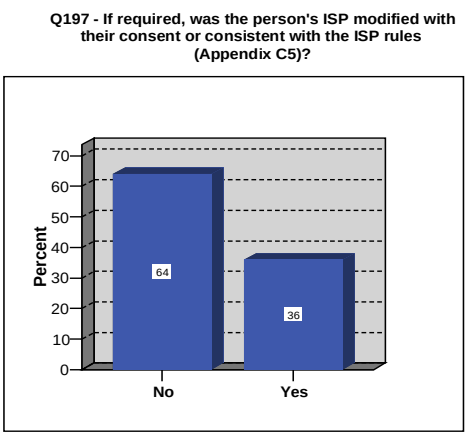
Seventy-seven (77) of the 141 "priority non-target site" class members reviewed (55%), were found to be treated with dignity and respect. Items related to this determination that have not been previously cited in this report include evidence that the clinical team offered various treatment options for the person to choose from and whether the clinical team continually made efforts to engage the person in rehabilitation, treatment and support services.

Seventy-two percent (72%) of the class members in this group were found to have been provided a variety of treatment options. Fifty-seven percent (57%) of the class members were found to have clinical teams that made continuous efforts to engage the person in services.

Non Priority Class Members
Appendix C Data



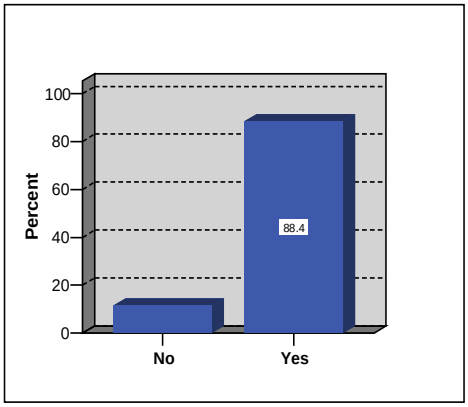
Appendix C, Criterion 3: *Within ninety days of a determination of eligibility, priority clients whose clinical needs required extended ISP's have extended ISP's, with a functional assessment and long-term view.* Although this item is not applicable per the Court's orders to Non-Priority individuals; the review did measure the status of compliance with this item. For the 148 individuals reviewed, 48% were found to have an ISP with a long term view and functional assessment. Overall, this is substantially the same from the date found in the 2005 Audit.



Appendix C, Criterion 5: *Whenever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program or a termination of services, class member's ISPs are modified with the clients consent or consistent with the ISP rules.* Twenty-six (26) of the "non-priority" class members had a substantial change in services in the past year. Of these, one (1) situation was considered not applicable because the person had initiated or consented to the change. For the other twenty-five (25), it was found that the ISP had been modified for thirty-six percent (36%), or nine (9) of the class members. Overall this represents a 21% increase from the findings of the 2005 Audit.

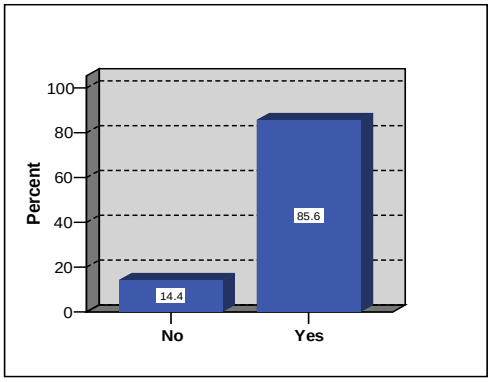
Appendix C, Criterion 6: *Class members are informed of their rights to appeal eligibility and treatment decision.* One hundred thirty (130) "non-priority" class members (88%) were found to have been informed of their right to appeal eligibility and treatment decisions. This determination was based on whether the person had signed the required documents or had verbally revealed that they understood the grievance process. Overall, this represents a 15% increase from the findings in the 2005 Audit.

Q212 - Class members are informed of their right to appeal eligibility and treatment decisions. (Appendix C.6)



Appendix C, Criterion 9: *Class members participate in the planning and development of their ISP if one exists, their treatment plan if no ISP is available, or the Special Needs Treatment Plan for inmates of the jail.* This criterion was not applicable for two "non-priority" class members who had been in services less than ninety days. Of the 146 class members for whom this criterion was applicable, 125 (86%) were found to have participated in the planning and development of their ISP. Overall, this represents a 28% increase from the findings in the 2005 Audit.

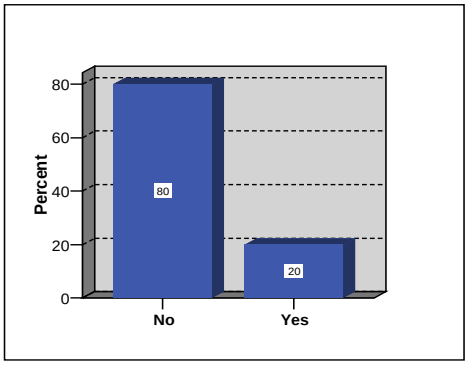
Q216 - Did the person meaningfully participate in the planning and development of their ISP? (Appendix C.9)



Appendix C, Criterion 10: *Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RHBA in the ISP and grievance process.* This criterion is evaluated through three questions:

- Did the clinical team assess whether the person needed special assistance in the ISP and grievance process?

Q185 - If special assistance is needed, is it currently being provided or offered by ADHS or the RBHA (Appendix C.10)?

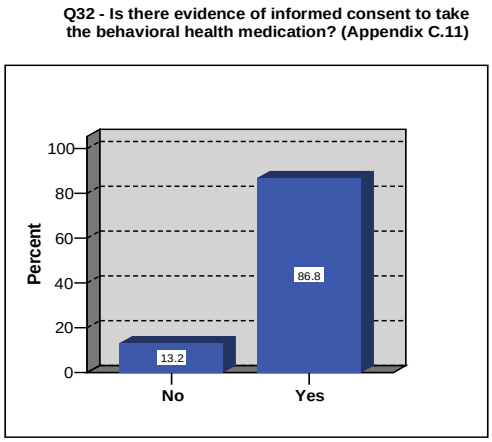


- Regardless of the team assessment/decision, is there evidence that the individual requires special assistance?

- If special assistance was needed, was it provided by ADHA or the RBHA?

For the first question, 128 (87%) of the "non-priority" class members had been assessed by the team for the need for special assistance. Four (4) class members were found to need special assistance due to physical or cognitive deficits, or language difficulties that interfere with the person's ability to communicate effectively. Of these five individuals, one (20%) was found to be receiving the special assistance needed to participate in the ISP and grievance process. Overall, this represents a 30% decrease in compliance from the 2005 Audit findings.

Appendix C, Criterion 11: *Class members' charts show documentation of adequate informed consent to medication, ECT, and surgically related procedures to address mental health conditions.* This criterion was measured through three questions:



- Is the person currently prescribed behavioral health medication?

- Is there evidence that the person/guardian provided verbal or written consent to take the psychiatric medication?

- Is there documentation of adequate informed consent to ECT or surgically related procedures to address mental health conditions?

The reviewer was unable to determine if one "non-priority" class member was currently prescribed behavioral health medications. One hundred forty-four (144) of the 147 "non-priority" class members for whom this could be determined were being prescribed behavioral health medications through the RHBA. Of these 144 class members, evidence of verbal or

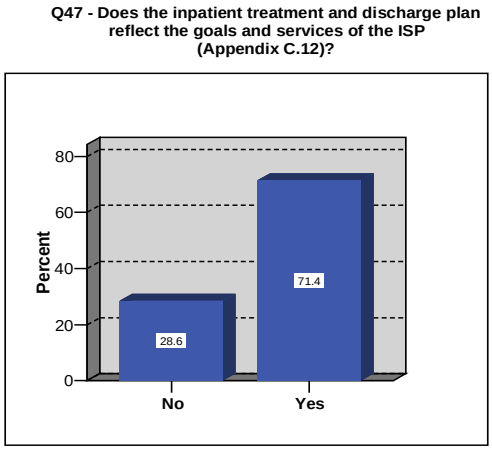
written consent to take the medications was found for 87%, or 125 individuals. None of the class members reviewed in this group had undergone ECT or surgically related procedures to address mental health conditions, so this question did not factor into the overall compliance of this criterion for this group. Overall, this represents a 3% increase from the 2005 Audit findings.

Appendix C, Criterion 12: *Class members, if still remaining for more than seven days in an inpatient treatment setting, have and ITDP by the tenth day, which is derived from their ISP, or from the treatment plan if one exists.* Three questions addressed this criterion:

- Has the person had an inpatient admission within the last 12 months?

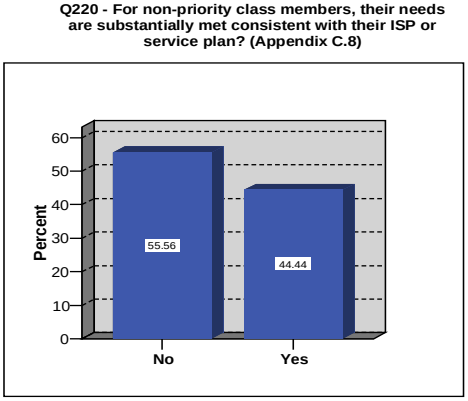
- Was an inpatient treatment and discharge plan developed by the 10th day of the inpatient stay?

- Does the inpatient treatment and discharge plan reflect the goals and services of the ISP?



Twenty-five (25) of the 148 "non-priority" class members had an inpatient admission in the past year. However, only 19 individuals had admissions that lasted longer than 10 days. Of these 19 class members, thirteen (13) had ITDPs developed by the 10th day of admission (68%).

Of these same 19 class members; one ITDP was not completed by the 10th day but was available for review on the second part of their criterion. Of the fourteen (14) ITDPs reviewed, ten (10), or 71%, reflected the goals and services of the ISP. Overall, this represents a 46% increase from the 2005 Audit findings.



2006 INDEPENDENT REVIEW
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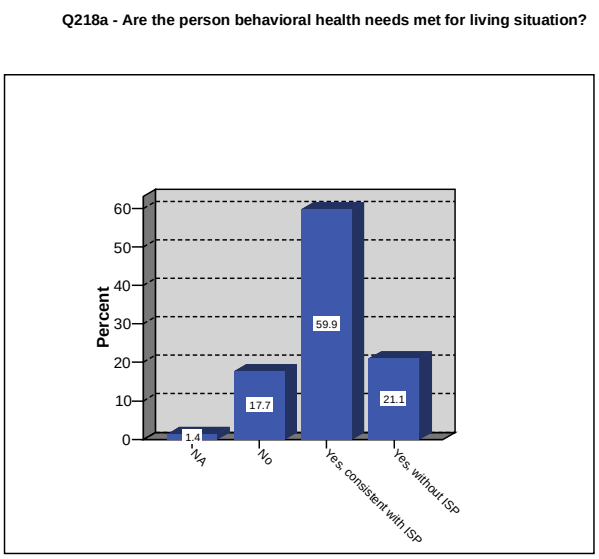
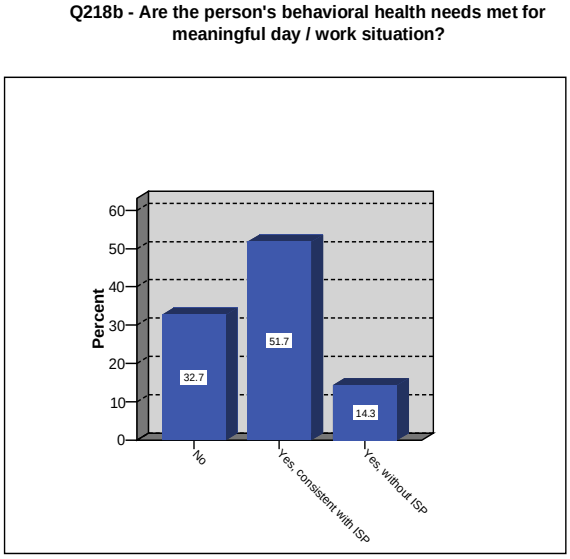
***Appendix C, Criterion 8**: The needs of class members are substantially met consistent with their ISP.* This criterion requires that each "non-priority" class member has his/her behavioral health needs met in two life areas (living, working/meaningful day) and the ISP must reflect the services and supports needed in each of these life areas. This item was not applicable to two of the "non-priority" class members because they had been enrolled in service less than ninety days. Of the 146 class members for whom this item was applicable, sixty-five (65) were found to have their behavioral health needs met in the areas of living and working/meaningful day consistent with their ISP, resulting in 44% compliance. Overall, this represents a 3% decrease from the 2005 Audit findings.

In the area of their living situation, 88 of those individuals (60%) had their needs met consistent with the ISP. In the area of working/meaningful day, 76 class members (52%) had their needs met overall consistent with their ISP. As previously mentioned, the following tables will provide the additional information needed to completely understand and analyze the findings.

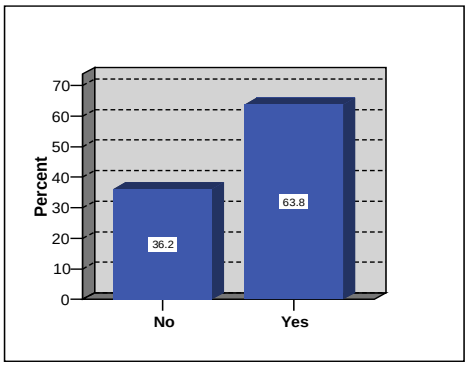




Again, employment is an integral component of rehabilitation and recovery. The results of the review found that 33 (25%) of non priority class members were working full or part time at the time of the review, with 101 (75%) of these individuals not working in any capacity.

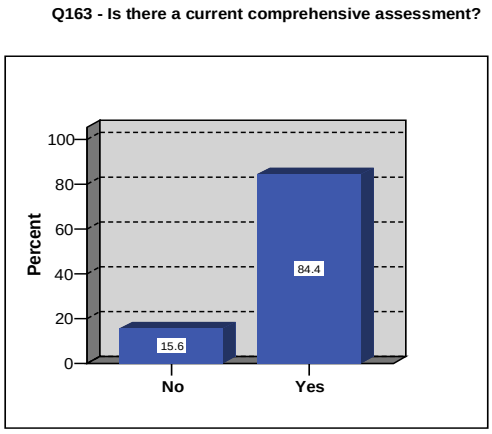
Non Priority Class Members

Supplemental Agreement Data



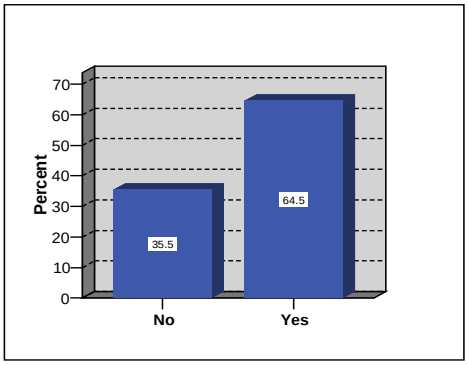
1. Coordination of Care with PCP. The item was not applicable to seven (7) "non-priority" class members who were not assigned to a PCP. Of the 141 individuals for whom this was applicable, 64% were found to have their behavioral health care coordinated with their PCP. Overall, this is a 10% increase from the 2005 Audit findings. It was also found that 75% of class members in this group had their physical health needs met.

2. Comprehensive Assessment completeness, relevance and timeliness. Nineteen items comprising three questions in the protocol addressed the comprehensive assessment:



- Is the comprehensive assessment current?

- Does it include the following components: mental health status, legal status and apparent capacity, living environment, interpersonal and social skills, social setting, physical health status, level of daily living skills, criminal justice history, developmental history, employment or vocational training, education, language abilities, public and private resources/entitlements, substance use history, risk assessment, sexual behavior/sexual abuse, and recommendations/next steps.



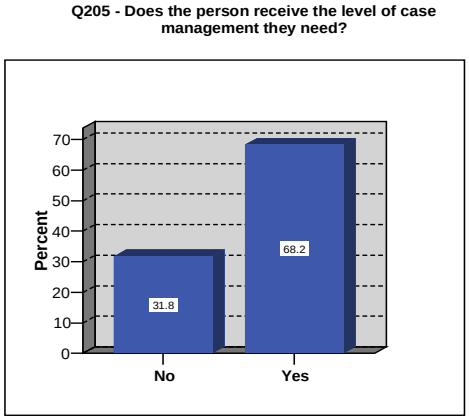
- Is the comprehensive assessment complete?

One hundred and twenty-four (124) of the 148 "non-priority" class members for whom this was applicable, had a current comprehensive assessment (84%). Of these, 65% were found to be complete in that the assessment addressed all applicable areas listed in the second bullet above. It should be noted that some areas were not applicable depending on the person's unique circumstances.

Three of the listed areas were found to not be addressed in the comprehensive assessment at least 80% of the time. These three areas and their lack of inclusion in the assessment are as follows: developmental history (applicable to 6 individuals); substance use history (applicable to 14 individuals) and sexual behavior/sexual abuse (applicable to 23 individuals). Overall, this represents an increase of 3% from the 2005 Audit Findings.

3. The case manager/clinical team's involvement in the day-to-day monitoring of the status of the class member and whether or not the recommended services are being delivered. Five items in the protocol address this issue:

- Does the case manager/clinical team respond to changes in the person's treatment needs and/or life circumstances in a timely manner?
- Does the person receive the level of case management they need?
- Is there evidence of communication between the person and each of the clinical team members?
- Does the clinical team assure that all services are in place in accordance with the ISP?
- Does the case manager/clinical team monitor the services the provided?

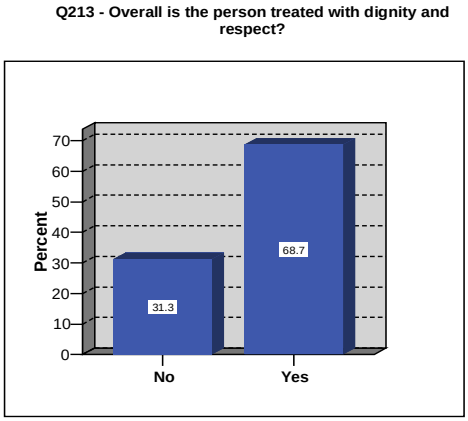


It was found that the case manager/clinical team provided a timely response to changes in the person's treatment needs and/or life circumstances for sixty-six percent (66%) of the "non-priority" class members reviewed. Sixty-eight percent (68%) of the class members in this group

were found to be receiving the level of case management needed. This represents an 8% increase from the 2005 Audit findings. Evidence of communication between the person and each of his/her clinical team members was found for seventy-two percent (72%) of those reviewed in this group. Fifty-eight percent (58%) of this group were found to have clinical teams assuring that all services are in place in accordance with the ISP and seventy-one percent (71%) were found to have their services monitored by the case manager/clinical team.

4. The class member is treated with dignity and respect by the case management agency, provider and any other involved individual.

This determination is based on consideration of the following factors:



- Indication that the person is treated as a unique and valued individual (such as class returned in a timely manner, etc.)
- Individual's rights are honored and protected (such as being given information, having a current ISP, etc.)
- Provision of special assistance, when applicable
- Person's input, preferences, choices and personal goals are included in the ISP process and their participation encouraged in the process (such as individualized goals and multiple attempts made to engage the person)
- Changes in the person's circumstances are responded to by the clinical team (such as timeliness of service provision and ISP revised when new or emerging needs develop)
- Ethnic and cultural differences are recognized and respected by the clinical team (inquiring about cultural preferences and incorporating these into the person's service provision
- All information gathered from all of the interviews conducted during the audit.

Sixty-nine percent (69%) of the individuals were found to be treated with dignity and respect. Items related to this determination that have not been previously cited in this report include

evidence that the clinical team offered various treatment options for the person to choose from and whether the clinical team continually made efforts to engage the person in rehabilitation, treatment and support services. Sixty-nine percent (69%) of the class members in this group were found to have been provided a variety of treatment options. Sixty-eight percent (68%) of the class members were found to have clinical teams that made continuous efforts to engage the person in services.

IV. SUMMARY & DISCUSSION

2006 INDEPENDENT REVIEW
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SUMMARY OF FINDINGS

The Independent Review was conducted during October and November 2006. The review focused on measuring ADHS' compliance with: *the Joint Stipulation on Exit Criteria and Disengagement, Appendix C; the Supplemental Agreement, and; the Stipulation Re: Revised Completion Dates* filed with the Court on May 23, 2006.

There were a total of 429 individual class members reviewed. Of these, 281 were priority class members and 148 were non priority class members. Priority class members comprise two groups: "priority target site" class members assigned to one of the six largest clinical team sites, and; "priority non-target site" class members assigned to one of the other 17 clinical team sites.

Significant preparation occurred prior to and throughout the 2006 Independent Review to strengthen the reliability and validity of the data contained in this report. I would like to express my appreciation to the ADHS/DBHS for providing staff support to help in all aspects of the review. I also extend my appreciation to Dr. Jose Ashford for providing continual technical and research expertise to the Office of the Monitor during this process.

The table below represents the findings from the 2006 Independent Review for each of the requirements contained in Appendix C. For the reader's ease, the definitions below have been shortened. Please refer to the body of the report for the complete requirement.

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Appendix C Compliance Table

Appendix C Requirement	Priority Target Site 2005	Priority Target Site 2006	Priority Non Target 2005	Priority Non Target 2006	Non Priority 2005	Non Priority 2006
Priority Clients have an appropriately constituted clinical team (C 2)	54%	71%	44%	64%	N/A	N/A
Priority clients have an ISP with a functional assessment and long-term view (C.3)	58%	35%	61%	34%	N/A	N/A
Priority clients shall have periodic reviews at least every six months. (C.4)	93%	82%	90%	75%	N/A	N/A
Substantial service changes result in modification to the client's ISP with the person's consent (C.5)	41%	31%	31%	50%	15%	36%
Class members are informed of their right to appeal eligibility and treatment decisions (C.6)	78%	89%	72%	92%	73%	88%
The needs of priority class members are met consistent with their ISP (C.7)	32%	30%	30%	28%	N/A	N/A
Living.	64%	60%	67%	49%	N/A	N/A
Working/Meaningful Day	36%	40%	42%	36%	N/A	N/A
Social/Community Integration	37%	46%	42%	44%	N/A	N/A
The needs of non priority class members are substantially met consistent with their ISP (C.8)	N/A	N/A	N/A	N/A	49%	44%
Living	N/A	N/A	N/A	N/A	74%	60%
Work/Meaningful Day	N/A	N/A	N/A	N/A	58%	52%
Class members participate in the planning and development of their ISP (C.9)	66%	83%	66%	75%	58%	86%
Class members in need of special assistance are offered or provided reasonable assistance (C.10)	56%	36%	38%	35%	55%	20%
Class members' charts show documentation of adequate informed consent to medication and ECT if applicable (C.11)	71%	85%	85%	77%	84%	87%
Class members have an ITDP by the 10th day of admission to an inpatient treatment setting.	71%	73%	53%	77%	50%	68%
The ITDP is derived from the class members ISP (C.12)	14%	71%	74%	44%	25%	71%

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The table below represents the findings from the 2006 Independent Review for each of the requirements contained in the Supplemental Agreement.

Supplemental Agreement Compliance Data

Supplemental Agreement Requirement	Priority Target Site 2005	Priority Target Site 2006	Priority Non Target 2005	Priority Non Target 2006	Non Priority 2005	Non Priority 2006
Coordination of Care with the Primary Care Physician	60%	65%	51%	49%	54%	64%
The person's physical health related issues and needs are being addressed.	50%	65%	54%	62%	55%	75%
The Comprehensive Assessment is current.	99%	88%	96%	80%	83%	84%
The Comprehensive Assessment is complete.	57%	57%	51%	46%	62%	65%
The case manager/clinical team respond to changes in the person's treatment needs/life circumstances in a timely manner.	47%	60%	48%	58%	52%	66%
The person receives the level of case management they need.	62%	69%	50%	53%	60%	68%
There is evidence of communication between the person and each of the clinical team members.	--*	79%	--*	64%	--*	72%
The clinical team assures that all services are in place in accordance with the ISP.	45%	60%	36%	53%	43%	58%
The case manager/clinical team monitor the services provided.	50%	73%	41%	66%	48%	71%
The class member is treated with dignity and respect by the case management agency, provider and any other involved individual.	--*	71%	--*	55%	--*	69%

*= no comparison data from 2005 available

This data shown above is summarized for the three groups reviewed in the sample: priority target site; priority non target site, and; non priority. The summary tables identify the source of the requirements, e.g. Appendix C, or in the Supplemental Agreement.

Finally, while there were changes made to the Audit protocol and process this year, it is still useful to be able to compare the results to those from the 2005 Audit.

Priority Target Site

Appendix C

These findings show that two requirements established for C.2 and C.9 contained in the *Stipulation Re: Revised Completion Dates* were achieved. The requirement established for C.2 was 70% and for C.9, 72.5%. When these two compliance items are compared to the findings of the 2005 Audit, the results for both indicate substantial improvement. The data shows that compliance for each increased by 17%.

The remaining two requirements contained in the *Stipulation Re: Revised Completion Dates* were not met. The requirement established for C.3, was 70% and for C.7, 55%. When these two compliance items are compared to the data found for the 2005 Audit, there was a decrease of 23% for item C.3 and the data for C.7 was relatively the same.

For six other compliance items contained in Appendix C, the data shows extremely poor performance on two items: C.5 (31%) and C.10 (36%). Of the remaining requirements, C.4, C.6, C11 & C.12, all achieved compliance of at least 70%.

Supplemental Agreement

For the priority target site sample, the results show that compliance for most items is between 60-79% However, when compared to the results of the 2005 Audit, the findings show an increase in compliance for six requirements (60%), a decrease or no change for two requirements (20%) and two items for which a comparison can not be made (20%).

Priority Non Target Site

Appendix C

There are ten compliance items contained in Appendix C. The results ranged from 28% - 92%. Three requirements achieved less than 40% compliance; three items were between 50-69%, three items between 70-79% and one item that scored above 90%.

Four (40%) of the requirements showed an increase when compared to the findings from the 2005 Audit (C.2, C.5, C.6 & C.9); four (40%) requirements showed a decrease (C.3, C.4, C.11 & C.12) and two (20%) showed only a slight difference (C.7 & C.10) from the 2005 Audit.

Supplemental Agreement

Overall, compliance scores for this group are concerning in that they are quite low. Compliance for two (20%) of the requirements fell below 50%. Seven (70%) of the ten items fell between 50-69%.and, for one (10%) item, compliance was 80%.

When compared to the results of the 2005 Audit, the findings show an increase in compliance for four (40%) requirements, a decrease or no significant change for four (40%) requirements and two (20%) items for which a comparison can not be made.

Non Priority

Appendix C

There are eight Appendix C requirements that apply to non-priority class members. The findings show a range of compliance from 36%-88%. Three (37%) of the requirements fell below 50% compliance. Of those requirements remaining (63%), achieved above 68% or above.

It is noteworthy that five (63%) of the Appendix C requirements showed an increase from the 2005 Audit (C.5, C.6, C9, & C.12). There was a significant decrease in compliance for item C.10. For C.8, there was a relatively slight decrease of 5% and for C.11 a slight increase of 3%.

Supplemental Agreement

The range of compliance for the ten applicable items contained in the Supplemental Agreement was 58-84%. There was very poor compliance of 58% for one requirement. The majority of requirements, (56%) fell between 60-69% compliance and four (44%) achieved above 70%.

When compared to the results of the 2005 Audit, there is an increase in compliance for five (56%) of the requirements contained in the Supplemental Agreement. One item showed a slight increase and one item a slight decrease when compared to the results in 2005. The data for two requirements was not available to be compared.

DISCUSSION

For some areas, compliance improved. For example, when compared to the 2005 Audit, more priority class members were assigned to an appropriately constituted clinical team and more class members had a "current" ISP. The percentage of class members who participated in the planning and development of their ISP also increased.

The problem, however, seems to be these findings do not result in improved clinical practice or better quality of care for class members. Fewer priority class members had a periodic review of their ISP and when they were reviewed, changes to the ISP were not facilitated when the person needed a change. Fewer comprehensive assessments were found to be complete.

In this review, we added a new classification of "Yes, without ISP." It is important to note that several individuals in this class had needs met, but errors occurred in actual documentation. In these cases, the consumers had the necessary clinical supports and treatment, but these interventions were not documented in the ISP. However, we know that spontaneous remissions and improvement in problems can occur without intervention. Indeed there are indicators in the data that point to poor quality that suggest that other factors besides documentation errors are contributing to needs being met without ISP. Namely, we cannot rule out that extra-system factors or factors associated with non-system interventions are contributing to the needs being met without ISP.

In essence, the needs met without ISP also point to clinical quality issues in the system that require further scrutiny. For instance, although 88 percent of the class members at target sites had a current comprehensive assessment, these assessments did not address all areas of clinical importance in 43% of the cases. What are the consequences of this lack of attention to these areas to various levels of service provision? Are poor assessments contributing to the 30% of class members at target sites not having the level of case management that they need? Does the lack of attention to criminal justice and substance abuse history in the assessments contribute to the dramatic increases in class members who were in jail or prison at the time of the review? Are the gaps in assessment observed in the audit process due to an overall lack of professional involvement in the system of service delivery? We need to address each of these concerns because 60 percent of the cases classified as "Yes, without ISP" did not have a complete comprehensive assessment. In other words, there is data in the audit process that suggests that the role of needs being met without ISP involves more than problems with documentation of information in the ISP.

Clearly, the quality of assessments impact many areas of service delivery, but these quality issues are further compounded by other evidence in the review concerning the level and the quality of professional involvement in each component of the service delivery process. For instance, the audit found that in only 50% of the cases classified as "Yes without ISP for living situation" that the case manager/clinical team followed up on changes in the person. In addition, forty-five percent of the cases in this classification did not have the level of case management that it needed and 40% of these cases did not have an appropriate clinical team. These results illustrate that there are still important capacity and system responsiveness issues affecting the system's ability to induce change that should be consistent with a person's ISP. In other words, the data showed that cases classified as "Yes, with ISP" had different levels of professional involvement from that of individuals classified as "Yes without ISP": 86% of the cases classified as "Yes with ISP in living situation had the level of case management that it needed and 68% of these cases had a comprehensive assessment that was complete. These findings show that there are clear service quality differences between cases classified Yes with ISP and cases classified Yes without ISP.

These same comparisons were computed for social/community integration needs. Similar trends were noted in these findings. Namely, 56% of the "Yes without ISP" had the level of case management that it needed compared to 92% of the Yes with ISP. In addition, 59% of the Yes with ISP in Social/Community integration had an appropriate clinical team in comparison to 81% of the Yes with ISP. In essence, there appears to be a relationship between the involvement of clinical professionals and needs being met that is in addition to whether there are changes that are identified in the ISP.

In sum, the needs being met, is a complex issue that can be influenced by errors in documentation and clinical quality matters. For this reason, reviewers of these results must be cautions in interpreting the findings involving needs being met without ISP.

There are a number of other changes that have been made since the completion of this audit that could have a significant impact on the sustainability of the improvements that are noted in the Audit Findings. The "field portion" of this review was completed on November 3, 2006. Value Options underwent reorganization and Reduction in Force (RIF) in mid to late November 2006, after the data collection phase of the Monitor's audit was completed. The information available indicates that the direct care clinic sites experienced a reduction of 80 full time positions. In addition, there were approximately 17 transportation specialist and 18 benefit specialist whose positions were abolished. At this time there is no way of knowing the impact of a reduction of one-hundred and fifteen (115) staff that either directly provided services to class members or supported the clinical teams in their daily work. It does call into question the likely hood that the improvements noted will be sustained over time.

Additionally, there have been across the board funding cuts experienced at Value Options. Many of these reductions in funding will also directly affect many of the providers who deliver services to the class members. Again, it is unclear as to the extent of these funding cuts and the negative impact it may have on service delivery to class members. Given all these factors, the improvements in compliance may be very fragile and not sustainable over time. It is imperative that the Parties have substantive discussions regarding not only these issues but the quality of care concerns discussed above.

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