REPORT OF DENNIS R. JONES, MSW, MBA

In the Matter of
Williams v. Blagojevich

(Case No. 05C-4673)

September 8, 2008

I. TRAINING AND EXPERIENCE

I have over 27 years of extensive leadership experience in public mental health settings. For a total of 13 years, I served as Mental Health Commissioner for two different states – Indiana and Texas. I was appointed Mental Health Commissioner in Indiana in 1981 and served until 1988. I reported directly to the Governor and had responsibility for eleven different state facilities (mental health and mental retardation), in addition to overseeing over 60 local providers who served persons with mental illness and/or substance abuse and mental retardation/developmental disabilities.

I served in a similar position in Texas from 1988 to 1994. As Commissioner of the Texas Department of Mental Health and Mental Retardation ("TDMHMR"), I reported to a nine-member Governing Board. I had direct funding and oversight responsibility for twenty-six (26) state-operated facilities for persons with mental illness or mental retardation. TDMHMR also funded and monitored thirty-five (35) local mental health authorities. I inherited and successfully resolved during my tenure two long-standing class action lawsuits (RAJ and Lelsz) that involved the state facilities for mental illness and mental retardation. One of the major elements of the Lelsz resolution was the successful transition of approximately 700 individuals with mental retardation from residential "state schools" for people with mental retardation to community settings. As a result, two state schools were phased out and closed.

From 1994 to 2003, I was the Administrator/CEO of Midtown Community Mental Health Center in Indianapolis. Midtown is an urban-based community mental health center that provides comprehensive services to over 13,000 youth and adults with mental illness, severe emotional disturbance and/or substance abuse. Midtown provides 24-hour crisis services, clinical therapies, psychosocial rehabilitation, Assertive Community Treatment ("ACT") teams, and supervised residential and supported housing, among other services. Many of Midtown's

consumers with serious mental illness had institutional histories – including over a hundred that came directly from a state hospital in Indianapolis that was closed. Based on my experience, I am familiar with the policies, processes, and services needed to transition persons from institutions to community-based care.

Since April 2000, I have performed significant roles in overseeing the District of Columbia's public mental health system. In April, 2000, I was appointed by a federal court as the Transitional Receiver for the District's mental health system as a result of litigation seeking reforms to that system to ensure adequate community-based alternatives for individuals with mental illness. In that capacity from April 2000 to May 2002, I ran the public mental health system in Washington D.C. and wrote a Court-Ordered Plan that details both the organizational structure and services for an effective system of community-based services. Subsequent to the Transitional Receivership, I became the Court-Appointed Monitor. I have served in that capacity since May 2002 overseeing the District's implementation of the Plan and achievement of nineteen (19) performance targets approved by the Court to end the lawsuit.

Since 2003, I have also been employed by Indiana University, working at the Department of Psychiatry, a Clinical Department of the Indiana University School of Medicine. I am the Chief Executive/Administrator for Indiana University Psychiatric Associates (IUPA), which runs a clinical practice plan and also a psychiatric managed care program for the University. The faculty practice plan provides direct mental health services to children and adults and also provides professional services to local psychiatric hospitals. In addition, I provide consultation to various state and local entities regarding behavioral health policy and practice.

I was also retained as an expert witness in Rolland v. Celluci in Massachusetts in 1999. That case involved issues of appropriate care and placement for persons with mental retardation

and other developmental disabilities who were living in nursing homes. In 2006, I was an expert witness in DAI v. Pataki, which involves the question of whether individuals with mental illness living in adult homes are appropriately integrated under the terms of the Olmstead decision.

My education and work history are detailed in my attached resume. IUPA is being compensated for my work on this case at a rate of $175 per hour.

II. SUMMARY OF REVIEW METHODOLOGY

My goal in this review process was to gain a broad understanding of the Illinois governmental and service delivery system for persons with mental illness. I also wanted to obtain a detailed understanding of the history, purpose and funding of nursing homes that are designated as Institutions for Mental Diseases ("IMDs"). The methods I utilized are accepted methods in the field and those I would employ in evaluating any state system.

A. Reviewed Materials that Informed this Report

In preparation for this report, I reviewed numerous documents. Those of particular note include: Illinois Disability Services Act Committee ("DSAC") Report; DSAC Services Plan Update (July, 2006); FY 2007 Community Mental Health Services Block Grant Application; Final Report on a Strategic Vision and Comprehensive Evaluation of the Illinois Public Mental Health System; Profile of Chicago's Mental Health System (2003); Critical Discussions for First Phase Redesign of MHPASRR; Illinois Nursing Home Regulations – including Subparts S & T; Illinois 2007 and 2008 Annual Comprehensive Evaluation Housing Plans; Illinois Housing Development Authority's 2007 Consolidated Plan Action Plan; Medicaid state plan amendments; Representative Julie Hamos' Discussion Paper: Moving Illinois toward a Cost-Effective Policy of Deinstitutionalization for Persons with Mental Illness (2002); defendants' responses to interrogatories and document requests; cost estimates from community mental

health providers; and numerous depositions and related exhibits of state officials, IMD administrators and state consultants.

B. Visits, Meetings and Phone Conversations

During calendar year 2007, I personally visited six IMDs where class members in Williams v. Blagojevich reside. I spoke informally to approximately twenty (20) residents, visited several resident rooms, observed common areas and discussed programs and services with IMD administrators and staff.

I talked with seven different Chicago-area mental health providers and visited on-site programs and services at four of the seven. The programs included psychosocial rehabilitation, community support and a range of residential and supported housing locations. During these visits I talked with staff and individual consumers, including several who had been or were currently residents of an IMD.

I also met personally or talked by phone with individuals who are knowledgeable about the range of mental health services in Illinois, Illinois' current policy and practice regarding utilization of IMDs, and Illinois' efforts to make policy changes with respect to mental health services. These individuals included three state association executives, two state legislators, a member of the Governor's Housing Task Force, leadership of the Disability Services Act Committee and a staff member of the Chicago Mayor's Office working on housing issues.

Through these meetings, conversations and visits, as well as review of documents and depositions, I became familiar with past, current and planned services for persons with serious mental illness in Illinois – with a focus on the Chicago area. In particular, I gained an understanding of the utilization of IMDs in Illinois, the nature of persons served in IMDs and the range of community-based mental health and housing supports provided to persons with serious

mental illness. All of the individuals I approached, including consumers themselves, were forthcoming and knowledgeable.

III. SUMMARY OF FINDINGS AND CONCLUSIONS

Based on my experience and expert analysis, including observations, interviews and review of depositions, interrogatories and other written materials, my opinions are as follows:

A. Illinois currently licenses and supports twenty-six intermediate care nursing homes classified as IMDs.[1] These IMDs typically house over 100 residents – the large majority of whom have been diagnosed with mental illness.

B. Illinois officials have created a public mental health system that ensures that thousands of persons with mental illness reside in IMDs.

C. IMDs are institutions and are not the most integrated setting appropriate to the needs of residents with mental illness. There is no reason to believe IMD residents are different from the many other people with mental illness residing in similar institutions across the country who have successfully moved to more integrated community settings.

D. Illinois has articulated a philosophy of community integration and true choice for all persons with mental illness; however, it has chosen not to implement this philosophy for persons in IMDs.

E. Illinois has a long history of funding and providing comprehensive mental health services, including both treatment and residential services. The residential services currently available include permanent supportive housing. The expansion of this community system to meet the needs of IMD residents would not require new kinds of services; it would simply require the expansion of services that already exist.

F. Community providers in Illinois are able and willing to expand community-based services to meet the needs of IMD residents.

G. Nonetheless, Illinois does not have a comprehensive, effectively-working plan for persons in IMDs to move to more integrated settings.

H. Illinois is aware that many residents in IMDs can and would choose to live in integrated settings if they were provided with meaningful choice and the needed supports. Yet, Illinois has not conducted a thorough needs assessment or financial analysis of the cost of placing IMD residents with mental illness into appropriate community settings, nor has it included IMD residents in most of its planning to promote community integration.

[1] Throughout this report, I use the term "IMD" to refer to these 26 intermediate care nursing facilities.

I. It would not be more costly for Illinois to provide more integrated community-based services for persons in IMDs. Illinois has the authority to regulate admissions into IMDs, the number of beds in IMDs, and the overall spending on IMDs. Illinois also has the capacity to reallocate dollars from institutional services to community-based services. Illinois would not have to fundamentally alter the nature of its services or programs to serve IMD residents in more integrated community-based settings including permanent supportive housing. It would only have to add capacity to existing services and programs and make those services and programs available to persons now living in IMDs.

IV. IMDs IN ILLINOIS

A. Introduction

Institutions for Mental Disease ("IMDs") are hospitals, nursing facilities, or other facilities of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The primary test for determining whether an institution is an IMD is whether 50% or more of the residents have a mental illness that was the reason for their institutionalization. The twenty six (26) IMDs in Illinois at issue in this litigation are intermediate care nursing facilities, which do not provide skilled nursing services. Approximately 95% of the IMD residents have mental illness. (Defendants' Answers to Plaintiffs' Second Set of Interrogatories No. 2). Admission to an IMD does not mean that a person cannot live in a more integrated community-based setting.

B. Federal Law Bars Federal Medicaid Reimbursement to States for Residents of IMDs

The federal government reimburses states for the costs of a wide variety of community-based mental health services provided through the Medicaid program. Federal reimbursement is generally at a rate of 50% or more. However, since the Medicaid program began in 1965, the Federal government has excluded from federal Medicaid reimbursement any services provided to individuals over age 21 and under age 65 who reside in an IMD. (42 CRF 1936d (i)). This is

known as "the IMD exclusion." The State, therefore, bears all of the costs for treatment and care of most individuals with mental illness who reside in IMDs.

C. History

The goal of this Federal statutory scheme, as evidenced by the Community Mental Health Centers Act of 1963 and subsequent legislation, was to promote community-based alternatives to institutional care. This federal funding policy, coupled with the growing understanding that congregate institutional care does not promote meaningful care, treatment or rehabilitation for most individuals, have, in large part, fueled the large-scale movement of persons with mental illness from state psychiatric hospitals to more integrated community-based settings.

This "deinstitutionalization" process reached full force in the 1960's and continues today in virtually all states. This process resulted from the increasing awareness, as reflected in the literature, that, while some individuals may need acute inpatient psychiatric care, individuals with serious mental illness are much more likely to recover and make rehabilitation gains (e.g. employment, illness management and connectivity to families) if their long-term care is provided in integrated community-based settings. Nationally, hundreds of thousands of previously institutionalized persons with mental illness have been moved or diverted to community-based services.

Unfortunately, some states, including Illinois, did not adequately plan for the full range of needs of individuals with mental illness. In those states, the pressure to downsize state hospitals led to the phenomenon of trans-institutionalization, which is to simply move individuals from state psychiatric hospitals to other less-expensive facilities, including nursing homes. The lack of sufficient community-based mental health treatment and residential services is at the heart of Illinois' and other states' trans-institutionalization.

D. Illinois' Decision to Utilize Nursing Homes/IMDs for Persons with Mental Illness

Illinois has used nursing homes as a means of trans-institutionalizing persons who would have previously been served in state hospitals. The number of people living in Illinois state mental hospitals fell from 42,000 in 1947 to 18,000 in 1970. (Final Report on Strategic Vision, pp. 108 & 114). By 2006, the state psychiatric hospital population had further dropped to under 1,500 people.

In contrast, approximately 16,770 people with psychiatric disabilities are currently living in nursing homes in Illinois and 4,440[2] of those are served in the IMDs at issue in this lawsuit. (Defendants' Answers to Nos. 2 and 3 of Plaintiffs' Second Set of Interrogatories). Some of these IMDs are large former half-way houses where discharged state hospital patients lived and were provided basic food and shelter but not mental health services. (Final Report on Strategic Vision, p. 112). Illinois eventually chose to license these facilities as nursing homes – providing a level of oversight, standards and potential federal Medicaid reimbursement. However, as the Federal government tightened its review of nursing facilities to ensure that states were properly applying the IMD exclusion, Illinois was required to designate these facilities as IMDs. Hence, for the large majority of individuals living there, the state pays 100% of the costs of their care.

In spite of obvious financial disincentives, Illinois has continued to rely heavily on IMDs; the number of people served per year in IMDs went from 5,413 individuals served in 2002 to 6,148 in 2006 – a growth of 735 (13.6%). (Defendant Barry Maram's Answer to No. 6 of Plaintiffs' First Set of Interrogatories). These for-profit IMDs actively recruit for new

[2] This number was provided by the defendants as reflective of the number of residents with serious mental illness living in IMDs on a particular date in June of 2008. This number does not reflect the total number of admissions over the course of the year, as the numbers for 2002 and 2006 do.

admissions. (Dennis Smith Deposition, p. 135). The IMDs generated aggregate profit margins of 22.4% for the period of 2000-2003. (Wyatt Deposition, Exhibit No. 4).[3]

What is clear is that Illinois has for decades utilized a setting that is inappropriate to the needs of persons with serious mental illness. This policy decision is outside accepted contemporary public mental health practice – which promotes individualized assessments, true consumer choice, integrated housing with supports, and recovery-oriented services that allow individuals to realize their human potential.

V. *OLMSTEAD* PLANNING

Based on my experience and expert analysis, including observations, conversations, interviews and review of written information and depositions, I conclude that Illinois does not have a comprehensive, effectively-working plan for community integration of persons in IMDs.

In order to develop a comprehensive plan, Illinois would have to take the following steps: 1) assess the abilities of IMD residents to live in more integrated settings and identify those with a desire to live in community settings; 2) determine the service needs of IMD residents who are able to live in a more integrated setting and would choose to do so; 3) determine the costs of making services available to these individuals in more integrated settings; and 4) develop an implementation plan to enable IMD residents to move to more integrated settings. Illinois has not taken any of these steps.

Illinois state officials acknowledge that the State has not included IMD residents in its planning for or provision of needed community services for people with mental illness and that the State's new initiatives to promote integration do little or nothing for residents of IMDs.

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[3] There is a recent initiative to identify newly admitted nursing facility residents who should be considered for community placements, as discussed on pages 11-12. This new initiative will not have any discernible impact on the current IMD population. (Hampton Deposition II, p. 56-57).

Illinois is fully aware that there are thousands of IMD residents with mental illness who could live in more integrated settings. A state-convened working group on supportive housing estimated in 2007 that at least 2000 IMD residents could live in more integrated settings. This working group, convened as part of the 2007 Illinois Housing Comprehensive Plan, recommended developing supportive housing for 2000 IMD residents with mental illness, but a key member indicated that "this was a very conservative" number by everyone's estimate and merely served as a starting point. (Phone Conversation with Janet Hasz, July 2, 2007). The chair of the working group noted that the working group believed the need was actually "much greater" than 2000. (Augustus Deposition, pp. 55-56).

Despite the State's awareness of these individuals, they are not included in the State's Olmstead planning. Illinois officials point to the creation of the Disability Services Advisory Committee ("DSAC"), an advisory body created by the state legislature in 2003, as the State's vehicle for Olmstead planning. The DSAC's plan to promote community integration contains no concrete provisions for IMD residents. Although the DSAC plan includes goals that broadly speak to services for institutionalized persons with mental illness (for example, expand funding for supportive housing for persons with mental illness), there is nothing in the DSAC plan that provides for making services in more integrated settings available to IMD residents.

Also, the DSAC plan is not a "comprehensive, effectively working plan" under Olmstead. The DSAC is viewed as an "advisory-only" body without any authority to make things happen. (Wyatt Deposition, p. 238). There have been no concerted follow-ups on recommendations made by DSAC.

A Disabilities Services Act passed in 2003 requires the State to collect data on the demographics and treatment needs of people with mental illness. However, the State does not

collect data on the service needs of individuals in IMDs. (Mary Smith Deposition, p. 11 and Exhibit No. 3). DMH has no plans to begin collecting such data for IMD residents. (Mary Smith Deposition, p. 95; Wyatt Deposition, p. 104). There is also no intent to include the overall needs of IMD residents in any strategic or operational planning being done by the DHFS or the Department of Human Services ("DHS"). (Wyatt Deposition, p. 104; Mary Smith Deposition, p. 143).

IMD residents are also largely excluded from the State's five year Money Follows the Person ("MFP") grant. This federal grant is intended to encourage the transition of Medicaid-eligible individuals from institutional long-term care settings to community settings. Under the conditions of the grant, the State has committed to move 640 persons with mental illness from nursing facilities to community settings, and will receive an enhanced federal Medicaid reimbursement rate for these individuals. No IMD resident under the age of 65 will be included in this effort.

A new rental assistance initiative and changes to Illinois' pre-admission screening process[4] similarly hold little promise for current residents of IMDs. Illinois' Pre-Admission Screening ("PAS") process requires initial screening of all individuals before admission into a nursing facility to determine whether they need a nursing facility. Historically, the PAS process has not been carried out as originally intended in Illinois – as acknowledged by state officials. (Dennis Smith Deposition, p. 29, Hampton I, May 10, 2007, pp. 58-63). Illinois has set criteria for admission so low that it fails to effectively divert individuals with mental illness from IMDs.

[4] Federal law does not require pre-admission screening to be done for nursing homes that are IMDs, but Illinois conducts these screenings for IMDs and has used them to approve placement of thousands of individuals with mental illness in IMDs.

The DMH has recently begun to tighten its PAS process for new admissions to nursing facilities. However, this new process would not impact any of the thousands of individuals with mental illness who have already been admitted to IMDs and remain there. (Hampton Deposition II, June 25, 2008, p. 12).

Illinois' new Bridge Rental Assistance program – which would provide one-time transition costs ($2000) and time-limited rental assistance for 600 to 700 individuals -- will likely have, at most, minimal impact on IMD residents. The Bridge Rental Assistance program has multiple priority populations competing for this small number of slots, including individuals currently residing in long-term care settings (which includes both IMD residents and nursing facility residents), individuals at risk of placement in long-term care settings, individuals who have been in state psychiatric hospitals for more than a year, individuals with mental illness aging out of the child welfare system, individuals in group homes, and homeless individuals. IMD residents are only a subset of one of these priority populations. State officials acknowledge that this program will have "very little" impact on IMDs. (Hampton Deposition II, June 25, 2008, pp. 56-57).

The State has not followed any of the principles articulated by the federal government in January of 2000 to comply with Olmstead. The federal government followed up on the Olmstead decision with a series of letters to states that provided direction on how states could meet their obligations to comply with the ADA as interpreted by the Olmstead decision. A January 14, 2000, letter to state Medicaid directors provided a comprehensive set of principles to states. These six principles are taken from the January 14, 2000, letter as follows:

Principle: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.

Principle: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

Principle: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

Principle: Ensure the availability of community-integrated services.

Principle: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

Principle: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

The State has not followed any of these principles with respect to IMD residents.

VI. IMD FINDINGS

A. IMDs are Institutions

Illinois officials acknowledge that IMDs are institutions. (L. R. Jones Deposition I, May 11, 2007 p. 165; L.R. Jones Deposition II, May 29, 2008, pp. 225-226). The context of creating the DSAC was to plan for the movement of individuals from inappropriate institutional settings (defined as state-operated facilities, ICF/DDs, nursing homes and IMDs) to integrated community settings. The Illinois Department of Human Services Division of Mental Health's Strategic Vision explicitly acknowledges that IMDs are institutions: "the inappropriate institutionalization of thousands of Illinois citizens in nursing homes and IMDs is perhaps the single most significant barrier to implementing a recovery vision." (Strategic Vision, p. 37).

My observation of and conversations with individuals in the six (6) IMDs that I visited confirms that these IMDs are institutions. People who reside in them are subject to very restrictive rules and procedures. Residents are typically subject to a behavioral management system that often limits an individual's ability to leave the facility until there are sustained periods of compliance. Residents eat in congregate dining areas with little to no choice over

food. Residents spend most of their waking hours either in their rooms, common TV areas, or in smoking areas. There are very limited activities available, and few organized skill-building activities that would prepare residents for community living. Even those residents who do go to outside mental health programs do so in a highly restrictive manner. There is little control over personal space with shared bedrooms and bathrooms. Many residents do not have control over access to their rooms and theft of personal property is a frequent concern. The pervasive sense of being told "what, when, where and how" leads to a loss of skills, forced dependency and loss of hope for the future. Residents receive $30 per month in a personal needs allowance, which does not allow them to save money to move into the community. As a result, IMD residents perceive their futures only in terms of living in an IMD.

IMDs are not integrated settings. The preamble to the U.S. Attorney General's regulations for Title II of the ADA defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." (28 CFR pt.35 App. A, p. 450, 1998). Residents of IMDs are all or virtually all classified as individuals with disabilities – with the large majority being persons with mental illness. Residents of IMDs live with and spend their time with other disabled individuals.

B. People in Long-Term Care Settings Across the Country Similar to IMDs Have Successfully Moved to Integrated Community Settings

The practice of public mental health has changed dramatically over the years. The original deinstitutionalization movement was fueled by a powerful combination of public outcry over inhumane conditions in state-operated facilities, the advent of psychotropic medications (1950's) and the beginning of a community-based system of care (1960's). Since that time, there have been successive waves of literature and evidence that people with serious mental illness can

live successful and meaningful lives in community-integrated settings. The 2003 President's New Freedom Commission on Mental Health affirmed the basic fact that even people with severe and persistent mental illness do recover in the right settings and with the right supports.

The national standard of care today is for persons with serious mental illness to live in integrated community settings with the supports necessary for them to succeed. The only exceptions may be persons with severe cognitive impairments, active behaviors that threaten public safety, or severe medical conditions that warrant continuous nursing care. These kinds of individuals are largely precluded by admission standards from living in IMDs in Illinois.

The addition of permanent supportive housing to the array of treatment options makes integrated community living entirely possible for individuals with severe and persistent mental illness.[5] Long-term care in congregate and isolated institutional settings is no longer acceptable practice. My past experience as a Mental Health Commissioner and Executive Director of a local mental health center has demonstrated that integrated community-based care based on a recovery model is appropriate and doable.

In my experience, most individuals in long-term institutional settings such as IMDs would choose to live in an alternative community setting if they were given a meaningful choice and assured that the necessary supports – including housing, treatment opportunities, and other supports -- would be in place. My experience has been that even those individuals who are initially unwilling to leave the institution will later choose to move if they are given time and meaningful options (for example, the opportunity to work with community staff in visiting programs and living options).

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[5] DMH supportive housing provides ongoing housing assistance, including start-up coasts. Flexible mental health services are linked with housing providing both the individual served and the landlord assurances that the array of living and treatment needs can be met.

My personal observation of and conversations with the individuals in the 6 IMDs I visited yielded no information suggesting that these are individuals who could not live successfully outside of an IMD. I understand that the other experts in this case have come to a similar conclusion. Many of the individuals in the IMDs have long histories of mental illness and institutional dependence. Moving these individuals from institutions to integrated community-based settings will require careful transition planning and training and support in activities of daily living. However, these are all tasks that community providers are equipped to do.

VII. FUNDAMENTAL ALTERATION REVIEW AND CONCLUSIONS

The State of Illinois has stated that "[t]he relief sought by Plaintiffs, if granted, would fundamentally alter the State's service, programs and activities..." (Defendant's Answer to Plaintiffs' First Amended Complaint, p. 30). I have examined the bases for this defense and have concluded that the State of Illinois has no factual basis for arguing that moving individuals from IMDs to community-based settings would be a fundamental alteration.

A. The Relief Sought Would Not Have a Negative Fiscal Impact

Based on my experience, my review of the evidence available, and my own analysis of relative costs, I conclude that moving individuals from IMDs to community settings would not have a negative fiscal impact on the state budget.

Illinois has not done any detailed fiscal analysis of the potential impact of moving individuals from IMDs to integrated settings. State officials designated as most knowledgeable about fiscal impact stated in depositions that their agencies have not done any fiscal impact analysis and they are not aware of any other agencies that have. (L.R. Jones Deposition II, May 29, 2008, pp. 271-272; Holler Deposition, p.17, 30).

State Representative Julie Hamos did an analysis in 2002 of the anticipated costs of moving individuals with mental illness from IMDs to integrated community-based settings. Her

analysis compared the costs to the State of serving individuals with mental illness in IMDs with the costs to the State of serving these individuals in integrated community settings. She included costs of the services provided by IMDs and community residential service providers as well as ancillary costs – the costs of services provided by others, such as physicians, pharmacy services, inpatient hospitalizations, and transportation. This analysis concluded there would be a savings in state dollars of $9,569 per person if individuals with mental illness were moved from the 100% state-funded IMD beds to community-based settings.

The State's interrogatory responses indicate that the FY 2006 average state cost for the IMD residents was $29,399, while the average state cost of serving individuals with mental illness in integrated community-based settings for FY 2006 was $12,030. (Answers of Defendant Barry Maram to Nos. 7 and 8 of Plaintiffs' First Set of Interrogatories). This $17,369 differential suggests that integrated community-based care would, in fact, be significantly less expensive than serving individuals in IMDs.

Three large community mental health agencies in the Chicago area provided me with detailed information regarding the full costs to support a representative cross-section of individuals (including those needing supervised residential, supportive housing and scattered site settings) who could transition from IMDs to integrated community-based care. These agencies included the costs for assessments, consumer engagement and initial start-up (e.g., security deposits, furniture, etc.). They also included costs for housing supports (including rental subsidies) in addition to the array of mental health treatment and supports that would be necessary to successfully support individuals in the community. This "full cost" model was offset partially by federal financial participation for currently approved Medicaid services for mental health. The net estimates ranged from a low of $17,200, and a middle estimate of

$20,112, to a high of $24,666. In my opinion, the lowest estimate $17,200 is the most representative and most closely follows the State's plans to focus new housing development on supportive housing rather than congregate care settings. Using these estimates, the net annualized average state cost including one time start-up, housing supports and mental health care was $20,660 per consumer. This does not include costs for certain ancillary services (for example, the costs for physicians, pharmacy services, inpatient hospitalizations, transportation).

This is significantly less costly to the State than serving individuals in IMDs, where the average net full year cost to the State for fiscal year 2007 was $ $27,534 per year excluding ancillary costs for medical and other expenses for services not directly provided by the IMD. (Defendants' Answers to Plaintiffs' Second Set of Interrogatories Nos. 5 and 7).[6] Even if all ancillary services are excluded from the state IMD costs, it still costs the state approximately $6,874 more per year to serve people with mental illness in IMDs than to serve them in integrated community settings.[7]

Moreover, if the cost of ancillary services is considered, the gap between the cost of serving individuals in IMDs versus in integrated community settings is even larger. The average net full year cost to the State for serving IMD residents in fiscal year 2007 (including ancillary services) was $36,776 per year. While no federal Medicaid reimbursement for ancillary services

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[6] Defendants' interrogatory response No. 5 indicates a total average cost of $3,064.73 per month - or $36,776 per year -- to Defendant DHFS for serving an IMD resident. For the sake of simplicity, I have used only the costs to Defendant DHFS and not the costs to Defendant DHS. The true cost to the state includes an additional $65.38 per month, or $784 per year, paid by Defendant DHS for IMD residents, for a total of $37,560 per year. These annual cost figures are higher than the $29,399 figure from Defendants' earlier interrogatory responses because the earlier figure would include partial-year costs for those individuals who stayed in IMDs for less than a full year. To obtain the cost of IMD services excluding ancillary services, I subtracted the average cost of ancillary services for IMD residents provided in response to Interrogatory No. 7 from the full costs provided in response to Interrogatory No. 5.

[7] The estimates actually include the costs of an array of mental health services for individuals in the community, which may be considered ancillary services for IMD residents. Thus, the savings for serving IMD residents in the community would be even greater.

is available for the vast majority of IMD residents, federal Medicaid reimbursement is generally available for ancillary services when provided to individuals in integrated community settings. Assuming that IMD residents would continue to have the same ancillary costs when they moved to the community,[8] I would anticipate that those costs – for which the State pays an average of $9,240 per year for each IMD resident[9] – would be federally reimbursed through the Medicaid program at a rate of 50 percent.

Whichever set of data is used, it is far more costly for the State to serve individuals with mental illness in IMDs than to serve them in integrated community settings.

In sum, I conclude that moving individuals with mental illness from IMDs to community settings would not have a negative fiscal impact.

B. Illinois has the Authority and Demonstrated Ability to Redirect State Resources to Appropriate Community Services

Illinois has the ability to allocate or reallocate dollars from one agency budget (or cost center) to another as individuals move out of institutions and into integrated community settings. Reallocation of resources can be achieved through multiple avenues, including through the annual budgeting process and through closure of IMD beds.

The State's own successful history of closing state psychiatric beds and moving individuals (and resources) to the community is an indication that Illinois has the authority and ability to redirect resources based on changing needs. (Vyverberg Deposition, pp. 14-20; Power Deposition pp. 14-21).

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[8] In fact, the ancillary costs for IMD residents would almost certainly decrease when those individuals moved to more integrated settings, where they would be able to make use of natural supports. For example, most individuals in supportive housing learn to use public transportation rather than using the expensive Medi-Car services used by IMD residents.

[9] Defendants' Answer to Plaintiffs' Second Set of Interrogatories No. 7 (ancillary costs for IMD residents average $770.15 per month - or $9,240 per year).

In Illinois government there are multiple examples of working across organizational boundaries to effect new policies and services. The 2006 Money Follows the Person federal grant is a good example of multiple agencies collaborating to redirect resources from institutions to community settings.

One of the basic tenets of the Money Follows the Person grant is, in fact, to have the "money follow the person." Illinois has multiple ways to accomplish this – at the beginning of the budget year, mid-year or an end-of year reconciliation. (E-mail from Marc Staley to Bob Greenlee regarding Money Follows the Person, April 18, 2008).

The Comprehensive Housing Planning Act (P.A. p. 94-965) is another example of multiple agencies, including DMH and the Illinois Housing Development Agency ("IHDA"), working in partnership to meet clear goals. In FY 2007, the State added $13.8 million in general revenue dollars (an increase of 43%) to provide supportive housing services through the Division of Mental Health. (Affordable Housing Dimensions, 2007 Annual Comprehensive Housing Plan, p. 4).

Some state officials have suggested that the "backfilling "of IMD beds with new individuals replacing those individuals who have moved to the community would interfere with the State's ability to shift resources from IMDs to community services. (Wyatt Deposition, p.187-192, 218). This is an unfounded concern. Illinois has multiple options to prevent the backfilling of IMD beds. The first is to put in place an admissions process that stops the inappropriate flow of persons with mental illness into IMDs. The severely diminished role and use of state psychiatric facilities that was achieved using this strategy is an appropriate parallel.

Second, the State has regulatory and rule-making authority over IMDs. The three agencies that relate to IMDs (DHS, DPH and DHFS) could jointly establish methods to ensure

that IMD beds – once vacated – are not filled. State officials acknowledge that this issue could be accomplished within the State's existing authority. (Wyatt Deposition, p. 219; Hou Deposition, p. 52; L.R. Jones Deposition II, May 29, 2008, p. 241).

Illinois has the authority and demonstrated ability to redirect state resources to appropriate community services.

C. Illinois has the Ability to Provide and Fund Integrated Community Services to IMD Residents

Illinois has an array of integrated community-based treatment and residential mental health services, including supportive housing, for individuals with mental illness--including high-need individuals. Affording IMD residents the opportunity to live in more integrated settings would not require new kinds of services, it would simply require the expansion of services that already exist.

Illinois has a 45-year history of providing and funding community-based mental health services to adults and children/youth with emotional or mental illness. The Division of Mental Health contracts with more than 162 community mental health centers/agencies and 28 community hospitals with inpatient psychiatric units. In FY 2006, the State served almost 175,000 persons. (Office of Management and Budget, FY '08 Governor's Budget Proposal, p. 17). Over 126,000 persons were between the ages of 18 and 64. (Strategic Vision, p. 76).

Illinois has recognized the vital importance of permanent supportive housing for successful community integration. In recent years, the DMH has undertaken a Systems Restructuring Initiative ("SRI") to put in place a recovery model. This model is based on the premise that individuals with mental illness can recover to such an extent "they can live fully and participate in the community." (Vyverberg Deposition, p. 52). The preferred DMH model for supportive housing is via existing scattered site apartments, (Hampton Deposition II, June 25,

2008, p.85), which avoids the time-consuming renovation and costs of new or rehabbed buildings. The DMH also provides for start-up and transition costs for some individuals through a Bridge Rental Subsidy program.

The DMH Director acknowledges that residents of IMDs need the same kinds of services that persons with serious mental illness in the community already receive; these services include housing, mental health services, non-traditional supports and employment. (L.R. Jones Deposition II, May 29, 2008, p. 304). Dr. Jones indicated that the "fundamental structure" of the system is in place to serve individuals currently in IMDs; the system simply needs adequate resources to grow the capacity to serve these individuals. (L.R. Jones Deposition II, May 29, 2008, pp. 304-305).

Illinois has already demonstrated that IMD residents with mental illness can successfully move to integrated community settings. Illinois recently funded a 2-year pilot program intended to move individuals from a discrete set of IMDs into the community. This Direct Connect program accepted some 87 individuals, of which 46 were placed into supportive housing. This program was viewed by the State as a successful model for transition. (Hampton Deposition II, June 25, 2008, p. 94). As the pilot funding ended June 30, 2007, these individuals (and costs) were successfully integrated into the existing array of community-based services.

D. The Inclusion of Adequate Community Support Services, Including Housing Supports, is Not a Fundamental Alteration of the Illinois Mental Health System

Illinois has stated the belief that "all persons with mental illness recover, and are able to participate fully in life in the community." (FY 2007 Community Mental Health Services Block Grant Application, p. 34). The SRI is an effort to operationalize this belief. (Block Grant, p. 34). While the State's vision and planning currently excludes persons in IMDs, it does not need

to. The State has acknowledged that the current service array is adequate to meet the needs of persons in IMDs. (L. R. Jones Deposition II, May 29, 2008, pp. 304-305).

An expansion of Illinois' supportive housing program in combination with necessary growth in other mental health services to meet the needs of IMD residents transitioning to integrated settings would not constitute a fundamental alteration of the Illinois mental health system.

E. Illinois has Local Providers Who are Willing and Able to Expand Services to Meet the Needs of IMD Residents

As Illinois has reduced its dependence on state psychiatric hospitals over the past 40 years, it has turned to community providers to meet the needs of individuals with mental illness. The current enrollment of nearly 175,000 individuals in the publicly-funded community mental health system—including individuals in supportive housing--is evidence that local providers are willing and able to serve this population.

The willingness and ability of local providers to expand services for IMD residents was confirmed in multiple conversations with local providers. Local providers were consistent in saying that IMDs are not appropriate settings for persons with serious mental illness and that their agencies could and would expand services for this population. The needed elements that were articulated by local providers included: 1) a clear state plan and phased process for implementation; 2) adequate funding including start-up funds and needed resources for housing supports; and 3) ongoing state leadership and commitment.

VIII. CONCLUSION

One of the unintended consequences of Illinois' deinstitutionalization from the 1960's to the1990's is that thousands of persons with mental illness ended up in other institutions – namely IMDs. While these IMDs were intended to meet basic living needs, they were never intended to

be, nor are they, adequate treatment facilities. Instead, they have functioned as institutions in the worst sense of the word – depriving individuals of their basic humanity in terms of lack of privacy, freedom to go outside and ability to make even limited choices. In such environments, people languish and lose confidence, skills and hope.

Parallel to this stark reality is an alternative reality – namely that integrated community care and recovery for persons with serious mental illness are possible – given the proper supports and opportunities. Illinois has embraced a recovery vision and has made some efforts to expand housing supports and employment supports as a part of this recovery-centered philosophy. Unfortunately, IMD residents are almost entirely excluded from integrated community services.

Illinois appears to recognize that reliance on IMDs is both unnecessary and costly to the State. Yet it has not developed a comprehensive, effectively-working plan to offer IMD residents the opportunity to live in more integrated settings. For these thousands of individuals, Illinois' failure to include IMD residents with mental illness in its planning for or provision of integrated community services means that they will remain needlessly confined in institutions.

Dated: September 8, 2008

Dennis R. Jones

RESUME

Name: **Dennis R. Jones, MSW, MBA**

Business Address: Department of Psychiatry
Indiana University
1111 West 10th Street, P.B. 201
Indianapolis, IN 46202
Telephone: (317) 278-9130
Fax: (317) 278-5865
Email: DRJones@iupui.edu

Home Address: 8017 Beaumont Green E. Drive
Indianapolis, IN 46250
(317) 595-8994

Education:

Wheaton College
Wheaton, IL
BA 1967
Major: Literature

Indiana University
Indianapolis, IN
Master of Social Work (M.S.W) 1969
Major: Casework

Butler University
Indianapolis, IN
Master of Business Administration (M.B.A.) 1977
Major: Financial Management

Professional Experience:

August 2003 – Present
Director, Division of Health and Behavioral Health Consultation for Indiana University, Department of Psychiatry. Consultant for major hospital planning project. Consultant to local CMHC. Consultant to State of Indiana as designated head of Mental Health Transformation efforts.

September 2002 – Present
President and CEO of Indiana University Psychiatric Management. Part-time CEO for single member LLC established to provide psychiatric managed care for contracted mental health plans.

January 1995 – Present
Administrator, Indiana University Psychiatric Associates, Inc., Indianapolis, IN. Part-time administrator for the practice plan, which is a 501 (C) (3) organization under the Department of Psychiatry for Indiana University School of Medicine.

May 15, 2002 – Present
Federal Court Monitor for Dixon. The Court Monitor's major roles are: ensure continued implementation of the Court-ordered

	Plan; measure progress via annual consumer services reviews; and develop methodologies to measure progress on Court-appointed exit criteria.
April 2000 – May 2002	Transitional Receiver for the District of Columbia's public mental health system. As part of the longstanding Dixon class action case, was appointed as the second Receiver by the Federal Court. Major accomplishments included: the development and Court approval of a comprehensive Plan for the District's mental health system; development and approval of legislation to establish a new mental health department; development and approval of a Court-monitoring Plan and exit criteria for underlying Dixon case; and establishment of new leadership, structure, and services for new mental health agency during transition out of Court Receivership.
February 1996 – August 2003	Executive Director, Chief Executive Officer, Vice President, Wishard Health Services/Midtown Community Mental Health Center Indianapolis, IN. Chief executive for large urban community mental health center with over 600 staff providing comprehensive mental health services and drug and alcohol services to children, adolescents, adults and older adults.
September 1994 – February 1996	Administrator, Midtown Community Mental Health Center, Indianapolis, IN.
July 1988 – September 1994	Commissioner, Texas Department of Mental Health and Mental Retardation, Austin, TX. Top state official for all public mental health and mental retardation services – including state facilities and contracted services to local mental health/mental retardation authorities, with operating budget of over 1 billion. Successfully negotiated resolution (and subsequent dismissal) of two long standing class action suits vs. TDMHMR (LELSZ and RAJ).
July 1981 – June 1988	Commissioner, Indiana Department of Mental Health, Indianapolis, IN. Top official for all mental health, substance abuse and mental retardation/dual diagnosis services for the state – including state-run facilities and contracted community services to local mental health and mental retardation providers.
1979 - 1981	Executive Director, Indiana Council of Community Mental Health Centers, Indianapolis, IN.
1976 – 1979	Administrator, Midtown Community Mental Health Center, Indianapolis, IN.
1974 - 1976	Program Director, Midtown Community Mental Health Center, Indianapolis, IN.
1971 - 1974	Team Director, Midtown Community Mental Health Center, Indianapolis, IN.

Consultations:

1995	Performed management audit for District of Columbia mental health system as part of a consent order under Dixon.
1999	Consultation to the District of Columbia regarding exit criteria for Dixon as proposed by first Court appointed Receiver.
1999	Provided expert witness consultation in area of systems design and impact in Rolland v. Celluci. Provided written report and deposition via engagement with the Center for Public Representation, Northampton, MA.
1999	Consultation for Magellan Health Services, Inc. Provided consultation on forensic mental health issues and related contracts in state of Indiana correction facilities.
2006	Provided expert witness consultation regarding systems performance under Olmstead in DAI v Pataki. Provided written report and deposition.

Professional Memberships (Boards or Commissions) from 1981 to Present:

- Addiction Services Advisory Council (Chair), 1981-1988
- Secretary, Governor's Commission on Future Directions in Mental Health, 1981-1982
- Juvenile Task Force, 1984-1988
- Governor's Task Force on Drunk Driving, 1983-1988
- Interdepartmental Board for Human Services, 1981-1988
- National Association for State Mental Health Program Directors
    - Board Member, 1985-1986
    - Treasurer, 1986-1987
    - President, 1988-1989
- Search and Screen Committee for Director of NIMH, 1987
- National Advisory Mental Health Council for NIMH, 1986 - 1990
- Advisory Council, University of Texas School of Social Work, 1989 – 1991
- Advisory Board, Indiana University School of Social Work, 1995 - 2001
- Board of Visitors, Indiana University School of Nursing, 1995 - 2000
- Community Board, Indiana University Department of Psychiatry, 1996 – 2003
- Chair, Statewide Task Force on Benefits Design for Statewide Commission on Title XXI – Children's Health, 1998 - 1999
- Chair, Statewide Task Force for Children-at-Risk for Statewide Olmstead Commission, 2002 – 2003
- Chair, Transformation Work Group for mental health systems redesign, 2005 – present

Awards:

- Charles Bosma Award for Outstanding Service to Mental Health, 1984
- Indiana University School of Social Work Outstanding Alumni Award, 1984
- Recipient, Sagamore of the Wabash, 1987
- Outstanding Achievement Award, Texas Alliance for the Mentally Ill, 1991
- Outstanding Service Award, Texas Society of Psychiatric Physicians, 1991

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CERTIFICATE OF SERVICE

I, Elizabeth J. Kappakas, an attorney, hereby certify that on September 8, 2008, a true and correct copy of the foregoing **Report of Dennis R. Jones, MSW, MBA: Williams v. Blagojevich,** was served upon the following attorneys of record for defendants via electronic and U.S. mail.

Thomas A. Ioppolo
Office of the Illinois Attorney General
100 W. Randolph Street, 13th Floor
Chicago, IL 60601

Ray J. Koenig III, Esq.
Peck, Bloom, Austriaco & Mitchell, LLC
105 W. Adams St., 31st Floor
Chicago, IL 60603

Elizabeth J. Kappakas