UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs	)	
v.	)	Civil Action No. 01-30199-MAP
DEVAL PATRICK, et al.,	)	
Defendants	)	

AFFIDAVIT OF DR. IVOR GROVES

I, Ivor Groves, hereby state as follows:

I. Qualifications and Experience

1. I am co-director of Human Systems and Outcomes (HSO), a consulting firm that provides evaluation, training, technical assistance and organizational development services to state and federal entities as well as private organizations so they may manage and measure the quality and consistency of their human services programs and implement effective systemic reforms. Since its founding in 1994, HSO has created multiple case practice review tools and processes that have been used in numerous jurisdictions across the human services spectrum. HSO is dedicated to improving the effectiveness of services provided to children, adults and families with special needs.

2. I have more than forty years of direct behavioral health, social service and education experience. My responsibilities have included management, policy analysis, practice development, system design, performance evaluation and serving as monitor for the federal courts. I have a Ph.D. in psychology from the University of North Carolina at

Greensboro (1976). I received a Masters of Applied Positive Psychology from the University of Pennsylvania in 2007.

3. I worked ten years in the Georgia mental health system (1969-1977), including five years as a licensed practitioner. Subsequently, I served in multiple managerial and administrative positions at the Florida Department of Health and Rehabilitative Services (HRS) from 1978-1984. Initially, I was the Program Administrator for Developmental Disabilities, and later served as the District Administrator for all human services in Southwest Florida, with responsibilities for a state hospital for persons with mental illness, a developmental disabilities institution, community programs for child welfare, mental health, and adult and aging, as well as all vocational rehabilitation, juvenile justice, Medicaid, benefit payments, and public health programs. From 1981 to 1984, I was the Deputy Assistant Secretary for all HRS programs throughout the State of Florida. In this capacity, I co-chaired the Department of Education/HRS interagency council. From 1988 to 1993, I served as the Assistant Secretary for Alcohol, Drug Abuse and Mental Health Services. In this role I was responsible for all program, financial and administrative management and oversight of substance abuse and mental health treatment programs throughout the State.

4. After working as a Research Associate Professor at the Florida Mental Health Institute of the University of South Florida, in 1994 I founded HSO to focus on improving the quality and consistency of practice and the measurement of system performance, frontline practice and outcomes for educational and human services programs. Over the years, HSO has acquired firsthand knowledge and experience in the complexities of dealing with public policy, multiple government funding streams,

legislative initiatives and coordination, and collaboration with professional communities and other stakeholders.

5. HSO has substantial experience in assisting government and private agencies in successfully accomplishing their goals in a professional and timely manner. I have been directly responsible for the design and implementation of policy development, strategic planning, grant preparation, budget development, broad-scale system change, system practice evaluations, as well as compliance assessment in several federal court system reform lawsuits..

6. My work at HSO has complemented my role and responsibilities as the court-appointed monitor in two major class action consent decrees involving child welfare and children's mental health services. I have served as the court monitor in two federal court cases from the beginning of the remedial phase until compliance was achieved: *R.C. v. Wally*, Civil Action No. 88-D-1170-N, United States District Court Middle District of Alabama Northern Division (2004-2006), and *Felix v. Lingle*, Civil Action No. 93-376, United States District Court of Hawaii (1994-2002). I also have been a court-appointed special master in another federal court EPSDT case,for children with serious mental illness, *Emily Q et. al. v. Diana Bonta*, 208 F. Supp.2d 1078 (M.D. Cal. 2001). Currently I work for the *Dixon v Fenty* court-appointed monitor in the District of Columbia, where I lead the compliance measurement of the exit criteria regarding the quality and consistency of practice in the District's mental health system.

7. I also have worked with Mental Health Systems of Care Initiatives and SAMHSA [Substance Abuse and Mental Health Services Administration] grantees in

Delaware, Georgia, Hawaii, Missouri, Indiana and New Mexico to assist and evaluate wraparound services and systems of care for children with emotional needs.

II. Individual Case Reviews Are Essential to Assess Compliance with the Court's Judgment and System of Care Implementation.

8. In 1984, I was hired to evaluate the status of services provided in state institutions and community programs for the developmentally disabled that was designed as a part of the remedy in *Lelz v. Cavanough*, a federal case in Texas challenging the unnecessary confinement of individuals with developmental disabilities and seeking the creation of community services and supports. The paper medical records (evaluations, treatment plans and progress documentation) that I reviewed were excellent and I was very favorably impressed. However, when I personally reviewed the services provided to class members, I discovered a dramatic disconnect between the services that the class members actually received and what was reflected on paper. There was virtually no correlation between the goals and treatment strategies in the written record, and what were actually being provided or not provided to class members. The quality and consistency of the implementation of treatment plans was extremely inconsistent and mostly poorly done or not done at all.

9. This experience in *Lelz* impressed upon me the need to obtain information from multiple informants and not to rely simply on records, data or other written documentation. It was this experience that, in part, led to the development of a qualitative case review method based on direct observation and interviewing of practitioners involved with the treatment team and the children and families. Such a qualitative case review method also enabled federal courts that were overseeing the

implementation of remedies or consent decrees to have independently collected data based on direct observation of the quality and consistency of frontline practices – practices that the remedies and consent decrees are intended to improve.

10. The qualitative case review method designated the "The Community Services Review" (CSR) is based on the fact that each child and family served is a test of the system. Children and families who seek services from a service system provider expect and deserve to be treated with respect, due diligence and without significant or detrimental error. The CSR abides by system of care practice principles that set forth the expectations that (1) children and families are respected and collaboratively engaged in the planning and delivery of treatment and evaluated carefully to insure that the treatment team understands their needs; (2) with the input of the child and family, the team decides on treatments and supports, and then delivers the agreed-on interventions and services without undue delay; and (3) if progress towards agreed-on goals is not being made, the team re-convenes and determines what other treatment options might be provided.

11. The CSR process selects a random sample of children being served by the system and seeks to determine whether the system practitioners in this particular child's and family's life are planning and delivering treatment and supports in accordance with the agreed-on practice principles. The expectation is that most children and families will be served most times with quality and consistency of practices that conform to the system of care practice principles.

12. Qualified CSR reviewers must complete 12 hours of classroom training and a series of supervised field experiences using the protocol. Candidate reviewers use the protocol in a shadowing/mentoring sequence involving a minimum of two

consecutive child and family reviews conducted in the field with an inter-rater agreement check made with the second case. The trainee's first case analysis and ratings, feedback session with frontline staff, oral case presentation, and first case write-up is coached by a qualified mentor. With the recommendation of the mentor, trainees who have successfully completed these steps participate on a review team under the supervision of the team leader and the case judge who approves written reports. Trainees may be certified after three successful reviews that meet the rating standards set by the expert review panel on the certification simulation.

13. In keeping with the CSR process, trained reviewers] conduct interviews with each person designated as a member of a child's team, including the child and the parent/caregiver. After completing all the interviews and reviewing the record, the reviewer rates both the status of the child and the family on key life domains as well as how well the system practitioners are executing each of the expected system functions. Such functions include efforts to engage the child, complete necessary evaluations and interviews with appropriate family member,, participate on the team, and plan and coordinate services. The reviewer compares what each person said about his or her participation in the planning and delivery of services to see whether team members are working together with a common understanding of all relevant issues.

14. The reviewer also determines whether services are being delivered in the agreed-on frequency and intensity, such as whether "weekly therapy" is actually occurring weekly. The reviewer also is able to determine the extent to which the child and families are satisfied with services.

15. Among the CSR indicators is the child status indicator. The child status information is used to provide a context and set of facts within which the system practitioners can be evaluated. Sometimes the child status is good and improving, but other times it is not good and may be getting worse. The focus of compliance is not the child status, but the degree of diligence on the part of the system practitioners to perform in accordance with the practice expectations. If they have been at least *mostly* diligent, then the system performance is rated acceptable, regardless of the actual status of the child. On the other hand, if they are not communicating with each other, not engaging with the family, and not delivering the agreed-on services, they are rated poorly.

16. The strength of the CSR is that it provides an organized way to use samples of persons served and judge whether at least the basic foundations of practice are being performed with diligence. It does not presume to judge the quality of therapeutic techniques used by a practitioner who is providing cognitive behavior therapy. It does, however, determine whether cognitive behavior therapy is being delivered reasonably in accordance with the agreed-on schedule and, if not, seeks to understand why it is not happening consistently through the interviews with the child, parent, therapists and other team members.

17. Because the data is collected by trained interviewers, they are able to ask questions in a flexible and inquiry-focused method that allows them to determine the actual quality and consistency of practices. They are focused on the actual delivery of quality interventions and treatments, and often find good practice even when documentation is weak, or conversely, weak practice when documentation appears to

indicate good practice is occurring. The information gathered is not limited by a specific set of survey questions.

18. The CSR also serves as a powerful and effective teaching and practice development process. Frontline practitioners find the input they receive to be highly useful in improving and refining both their individual practices and their collaboration with families and other service providers.

19. Thus, the CSR provides an organized method for an external determination and validation of the extent to which the services are delivered consistent with court judgments and consent decrees. Under this process, trained reviewers use the CSR tool that is designed specifically in the context of the system that is to be reviewed. The instrument is refined in each jurisdiction where it is used to reflect the specific requirements of the particular judgment or system practice expectations.

20. In Massachusetts, the CSR was designed to study and assess the System of Care implementation, including the provision of wraparound services, required by and consistent with Judgment in this case. As set forth in paragraph 22 of the Judgment, "the 'wraparound process' refers to a planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child to achieve a positive set of outcomes. The System of Care is a cross-system coordinated network of services and supports organized to address the complex and changing needs of the child."

21. The fundamental issue of system performance is the quality and consistency with which the practitioners perform in accordance with the agreed-on practice principles. It is left to the Court to determine the ultimate quality and

consistency necessary for at least minimal compliance, but clearly any compliance standard is based upon the provision of the agreed-on services and supports for most of the children and families much, if not most, of the time.

22. In the summer of 2009, HSO was contracted to assist the *Rosie D.* Court Monitor, Karen Synder, in the design of a protocol to measure compliance with the Judgment. Over the course of several months, I conferred with Ms. Snyder and her team of expert consultants about the implementation of the new remedial services. My understanding is that the parties were actively reviewing a work plan for CSR implementation during this time. In February 2010, I led and facilitated a two-day work session to design an effective protocol that ultimately could be used to measure compliance in this case. In addition to the Court Monitor and her expert consultant, Mary Brogan, who worked through the Technical Assistance Collaborative, other participants included national experts in system reform and in children's mental health as well as representatives from both the plaintiffs and the defendants. The protocol design was fully informed by the requirements of the *Rosie D*. Remedy, and included a crosswalk of the requirements and language of the remedy in order to assure consistency of measurement and terms. The result of the collaborative design process was an initial draft review protocol that was then distributed to all participants. Revisions were made as a result of the feedback received from all design group participants. HSO also participated in a field test of the protocol, which resulted in additional adjustments to the CSR protocol.

23. It is my understanding, based on conversations with Ms. Brogan and the persons actually making the edits on the protocol, that Ms. Snyder and Ms. Brogan have worked extensively to make adjustments and changes responsive to the defendants input.

For example, because various state agencies, like the Departments of Children and Families, Mental Health, Developmental Services and Youth Services are not named defendants, even though they are part of the Executive Office of Health and Human Services which is a defendant in this case, the revised protocol eliminated all ratings of the performance of these other state agencies. I also understand the edited protocol also no longer includes any evaluation of the quality of a child's Individualized Education Plan.

24. Ms. Sherwood's affidavit, which was submitted as Ex. 1 to the defendants' Motion, refers to a telephone conversation that I had with Ms. Snyder and the defendants, at the defendants' request. Based on Ms. Sherwood's affidavit, it appears she misunderstood my position with respect to scoring the child and care-giver status. Sherwood Affidavit, Doc. 503-1, ¶ 7, p. 3-4.

25. Contrary to Ms. Sherwood's representation, I believe it is critical that the child and care-giver status be reviewed and scored. This insures that reviewers have spent sufficient time and effort to understand the current status of the child and family to determine if the interventions and supports specified in the plans are reasonably well matched to the needs of the child and family. In the telephone conversation referenced above, the defendants expressed concern that they not be held accountable for things over which they had little or no control. I explained that it was critical that child and care-giver status be scored, as it was the foundation for the review and a number of other necessary determinations flowed from those judgments (score). I did state that the score assigned to rate the child and care-giver status should not be used to make judgments about the system performance. That is to say, as explained above, a poor rating or score

on child status does not mean that the system is necessarily performing below expectations or judgment requirements.

III. The Community Service Review (CSR) Has Been Used to Measure Compliance in a Number of Other Jurisdictions and Federal Court Cases.

26. The CSR process has proven to be an effective method for determining compliance in multiple federal class action lawsuits. It is widely used in many jurisdictions. For example, it is or has been used in child welfare cases such as *R.C. vs. Wally* in Alabama, *LaShawn v. Fenty* in the District of Columbia and *David C. v. Huntsman* in Utah and *** in Broward County, Florida; and in mental health cases including *Dixon v. Fenty* in the District of Columbia and *Felix v. Lingle* in Hawaii; and in EPSDT cases such as *Katie A. v. Bonta* in California and *J.K. v. Eden* in Arizona. In *J.K*, it was used as an independent evaluation of the systems performance which the judge used in shaping his remedy, and consequently was used as a measure of performance.

27. In addition to being an effective measure of compliance, the CSR is highly valued as an effective teaching and practice development tool for frontline practitioners. It is used or has been used, as a matter of choice, by the state mental health systems in Indiana, Missouri, and New Mexico to improve practices across all providers statewide and to provide comparable measures of performance across providers. It is also currently used in the child welfare systems in Utah, Wisconsin, Iowa, New Jersey, Tennessee.

IV. Conclusion

28. The Court Monitor's decision to rely on the CSR to measure compliance in the *Rosie D.* case is an acceptable and reasonable exercise of professional judgment.

The Court Monitor is not seeking to do something experimental or untested, but rather, is seeking to employ the same method for measuring compliance that has been adopted and used successfully by other federal courts and court monitors in comparable cases as well as multiple state mental health and child welfare jurisdictions. As noted above in ¶ 27, case reviews have been used as part of the federal evaluation of system of care grants and in all states to measure quality and consistency of child welfare performance.

29. The CSR will provide this Court with a valid and effective methodology to assess compliance with the implementation of the *Rosie D*. Judgment.

Signed under the pains and penalty of perjury, this _10 day of September 2010.

Ivor D. Groves

Dr. Ivor D. Groves