IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

UNITED STATES OF AMERICA — PLAINTIFF

VS. — CIVIL CASE NO. 3:16CV00622-CWR-FKB

THE STATE OF MISSISSIPPI — DEFENDANT

TRANSCRIPT OF HEARING

BEFORE THE HONORABLE CARLTON W. REEVES
UNITED STATES DISTRICT JUDGE

JULY 12, 2021
JACKSON, MISSISSIPPI

REPORTED BY: TERI B. NORTON, RMR, FCRR, RDR
Mississippi CSR #1906

2012 15TH STREET, SUITE 403
GULFPORT, MISSISSIPPI 39501
(228) 563-1748

APPEARANCES:

FOR THE PLAINTIFF:
DEENA FOX, ESQUIRE
PATRICK HOLKINS, ESQUIRE
U.S. DEPARTMENT OF JUSTICE
601 D STREET NW
WASHINGTON, DC 20004

REGAN RUSH, ESQUIRE
U.S. DEPARTMENT OF JUSTICE
950 PENNSYLVANIA AVENUE NW
WASHINGTON, DC 20530

FOR THE DEFENDANT:

JAMES W. SHELSON, ESQUIRE
REUBEN V. ANDERSON, ESQUIRE
PHELPS DUNBAR, LLP
POST OFFICE BOX 16114
JACKSON, MISSISSIPPI 39236-6114

DOUG T. MIRACLE, ESQUIRE
MARY JO WOODS, ESQUIRE
MISSISSIPPI ATTORNEY GENERAL'S OFFICE
POST OFFICE BOX 220
JACKSON, MISSISSIPPI 39205

TABLE OF CONTENTS

THE COURT: Good morning. I'm sorry. I'm having a slight computer issue right now, but this is United States versus State of Mississippi, 3:16cv622CWR-FKB.

As is this Court's typical practice in light of COVID, I'm not wearing my mask because I'm fully vaccinated. So are members of my staff. However, our court rules require -- I interpret my court rules to make sure that everyone who does not have on a mask is fully vaccinated, and I start with the attorneys for the government who don't have on masks. I need a representation from you that you are fully vaccinated.

MS. FOX: Yes, Your Honor, our team is fully vaccinated.

THE COURT: For the State of Mississippi?

MR. SHELSON: Yes, Your Honor, fully vaccinated.

THE COURT: Okay. Now, I know there are members in the audience here. I need representations because our court rules require that persons who come into the courthouse, and I don't know if you were requested or asked by the CSOs, but I'm asking each individual who does not have on a mask if you are fully vaccinated, and I need that representation made by each of you who are not wearing a mask. I see people putting on their masks now, in light of that. So I am going to assume, then, that everyone else has been fully vaccinated, and that is your official representation to the Court that you are.

We don't want to be the cause of any super-spreading

events or anything like that. I don't want y'all to be trying to sue me. You will lose.

MS. FOX: Your Honor, we have realtime set up here, and it doesn't seem to be feeding.

(PAUSE FOR TECHNICAL DIFFICULTIES.)

THE COURT: Thank you. Now, who is here for the United States?

MS. FOX: Your Honor, today this is Deena Fox for the United States. We also have Patrick Holkins and Regan Rush.

THE COURT: Thank you. And who is for the State of Mississippi?

MR. SHELSON: Your Honor, Jim Shelson and Reuben Anderson from Phelps Dunbar, and Doug Miracle and Mary Jo Woods from the Mississippi Attorney General's office.

If Your Honor would indulge me for a few minutes, can I introduce our three summer associates to the Court?

THE COURT: Yes.

MR. SHELSON: Your Honor, from left to right, Kelsi Baldwin, Gabby Wells, and Hunter Ransom.

THE COURT: Thank you, Mr. Shelson. I thought you were going to introduce the Lieutenant Governor to me. That is the first time the Lieutenant Governor has ever been in my courtroom. He needs no introduction.

MR. SHELSON: Lieutenant Governor Hosemann is here on behalf of the State. Wendy Bailey, the executive director of

DMH is here, and Bo Chastain at Mississippi State Hospital is also here, Your Honor.

THE COURT: Thank you, Mr. Shelson. I know this matter is important to the public. It is important to all of us. I think we have a live audio feed, I think, that's been made available to the public so that those who could not come here today can listen in on the proceedings. Again, it is important to all of us, and so I do acknowledge the presence of the state officers and others who are here today. I think it is important.

So we never did decide -- and I know my Special Master is here today. We -- as parties, as party participants with counsel, we never really decided on what this particular hearing would look like, how we would deliver the evidence that the Court believes that it needs and for the parties to get whatever information they believe that this Court must have in order to make a sufficient record. And I know this is very late notice, but if there's a -- I don't know if the parties have talked about the particular process. If you've agreed upon a particular process, let me know. I did -- there was some communication, I think from the Court, I think there was an inquiry of whether the parties would be allowed to ask questions of the Special Master, and I do believe the answer to that question was yes, you will be given that opportunity. But how do the parties wish to proceed?

If anyone has any -- this is one thing I want to do, make sure we agree on proper procedure because I don't want the procedural issue to be one which is a cause for concern later on for my good friends in New Orleans. So, you know, we sort of put errors aside at least procedurally. If there is. I mean, I'm not trying to put pressure on you at all.

MR. SHELSON: Your Honor, if I may for the State of Mississippi, the State's view is that the Special Master should proceed first, and the parties then question him, and then beyond that, it's the State's understanding that it's oral argument after that.

THE COURT: What is the United States' understanding?

MS. FOX: We came here to do whatever you ask us to do here today. We have prepared a brief introduction to our proposal that walks through in brief our -- the proposal that we sought. So at some point, and that could be after the Special Master speaks, we would be happy to offer that and answer any questions that you have.

THE COURT: Is your microphone on, Ms. Fox?

MS. FOX: It says that it is, but I think it needs to be moved.

THE COURT: That is fine, because the court reporter can't hear you. I remind the parties, please, make sure that you are speaking at a pace at which the court reporter can keep up with you.

I guess I do want, for the benefit of the public, I do want the parties first to just give an overlay of what your proposal is in a very simplistic way. Then we will have the Special Master talk about the work that he did, what he did, the information that he sought out, the details of everything that he did, and his particular recommendation based on what he's learned about this case, and the parties will be given an opportunity to follow up with questions, starting with the United States and then the State of Mississippi, since the United States is the plaintiff in this case. Then the State of Mississippi and United States will then have a brief opportunity for what I'm considering redirect.

And then at some point, we will give the parties an opportunity to further elaborate on why having heard the Special Master, maybe you decided that, hey, what the Special Master says is all that needs to be said and all that, and it may be -- but whatever else you want to do after that point, argument or whatever.

This may take a while, the Court has set aside -- and I know I indicated that we started a little bit earlier today, so the Court is here for the parties today. And I know that we expect to be done in time for people to make their travel plans. So that should be no problem.

So a brief introduction, because the public, Ms. Fox, may not have been -- they may have read your stuff a long time ago,

and they may not be fully informed, the Court may not be fully informed what your position is, but, please, take the time that you need to give us a brief introduction of what this litigation has revealed to the United States, and I will hear the same from Mr. Shelson.

MS. FOX: And if it's all right, Your Honor, I will present a general introduction, and then Mr. Holkins would like to address one issue that is the kind of central question that we had regarding the Special Master's report.

THE COURT: Okay.

MS. FOX: As you know, this case is about people who need and have not been able to access community-based mental health services, to be discharged from or avoid unnecessary segregation in Mississippi State Hospitals. A judicially enforceable remedial plan subject to monitoring by a Court-appointed expert is the only reliable way to ADA compliance for the State of Mississippi. That was true two years ago when the Court made liability findings, and it remains true today.

The Supreme Court has explained that federal courts must vigilantly enforce federal law and must not hesitate in awarding the necessary relief. This responsibility includes ordering narrowly tailored relief in this matter to prevent the repetition of the violation by commanding measures that will safeguard against that recurrence.

The United States has put forth a narrowly tailored plan for filling the major gaps that the Court identified in the state's community-based mental health system for serving people who are in or at serious risk of entry into a state hospital. The United States' plan is based on the core services that the State itself chose, that the State has implemented in parts of the state and has defined in its own standards. And the United States' plan seeks to make those services that are currently on paper a reality for people wherever they are in the state, if they need them to stay out of an unnecessary state hospital admission.

At trial, our experts testified that there's a bundle of effective services that will enable people to avoid those unnecessary admissions, and, of course, not every person will need every service, but availability of those services for every person who is at serious risk of hospitalization is necessary and required.

The United States' plan requires that the State expand that service capacity to achieve statewide availability within three years. At trial, you heard from people receiving and providing services. You heard from the United States clinical experts led by Dr. Robert Drake and from the State's own officials. And their testimony, along with the other evidence at trial, demonstrated people in all corners of Mississippi are experiencing unnecessary, repeated and lengthy state hospital

admissions, and that's why the United States' expert, Melodie Peet, testified that as a baseline, the State must make those core services available statewide.

The State appears to agree in broad terms that people across the state should have access to those services, and I will walk you through, Your Honor, the primary provisions that the United States included in its order to get to that result.

THE COURT: Hold on for one second, Ms. Fox. A couple of gentlemen have just entered the courtroom. You need to take a seat somewhere and represent to the Court -- I see you do not have on masks. Sirs, you need to make sure -- have you been fully vaccinated?

SPEAKER: Yes, sir.

SPEAKER: Yes, sir.

THE COURT: Okay. Thank you. I'm sorry, Ms. Fox.

MS. FOX: Absolutely. I will begin with crisis services. Arriving at a crisis too late or referring people in crisis to law enforcement, as we heard about at trial, results in unnecessary hospitalizations. In that case, it's as if mobile crisis doesn't exist at all.

The Court may recall the testimony of Sheriff Patten, where in his region, even though a mobile crisis team existed on paper, he was the one who was called on to respond to crisis. The State's proposal is to keep the status quo, which is not sufficient. The Special Master recognizes that timely

crisis response is critical and, in fact, can even prevent suicide, but it is critical that the order specifies the standard of timely response as a central element to mobile crisis, that the order incorporate the State's own standard of one-hour response time in urban areas and two-hour response time in rural areas as part of the required outcome.

Making crisis stabilization units available, another element of the crisis component, to people in all regions of the state is another way to provide a diversion option and prevent state hospital admissions. Again, the United States' plan, for that reason, includes a crisis stabilization unit in every region of the state. The State largely agrees, and the primary area of disagreement is on CSU coverage, crisis stabilization unit coverage for Region 15, for Warren and Yazoo Counties.

The State plan also doesn't call for a requirement of transitioning individuals to ongoing services before they are discharged from those crisis stabilization units and mobile crisis, which, again, is a necessary component to ensure that people who have experienced a crisis have what they need to avoid another crisis and a hospital admission.

Turning to PACT, a service that you heard much about at trial, we saw at trial maps of the heavy utilizers of state hospitals in this state, and you saw that there are people in every corner of the state who have spent significant time and

many admissions in the state hospitals. Many of them lived in regions or counties that did not have access to PACT services. The United States' plan calls for PACT access for people everywhere in the state.

The State, on the other hand, proposes maintaining its existing PACT services and then using two newly developed services instead of PACT in large swaths of the state, irrespective of whether they are as effective as PACT in preventing hospitalizations, and that would cover more than 15 counties of the state through some of these -- through the lowest level service that the State has identified.

The Special Master recommends that the Court accept the newly developed services that the State is offering, ICORT and ICSS, and he indicates that they should be subject to clear verification requirements, but the mechanics of that verification the United States believes are flawed. And my colleague, Patrick Holkins, will discuss that in a moment.

Turning to permanent supported housing, having a stable, safe, affordable place to live where people can then engage in treatment is an evidence-based approach to preventing unnecessary hospitalizations. According to the State's own estimates and the estimates based on the United States clinical review team, over a thousand people need access to permanent supported housing every year in Mississippi.

The United States' proposal includes an expansion of

permanent supported housing to a level that would nearly reach that estimate based on the client review.

The State wants to, on the other hand, expand permanent supported housing by fewer than one hundred units, well below any estimate of need by the State or any of the experts that presented at trial.

And the Special Master's proposal would fund 500 units in total, which is not an estimate that reflects any of the evidence at trial.

Turning to supported employment, having a job to provide both purpose and income is key to reducing hospital admissions. The Special Master has explained in his report that for many people with serious mental illness, supported employment is as or more effective in preventing hospitalizations as medication or therapy. The United States plan includes an expansion of evidence-based IPS supported employment throughout the state, and that is the model that the State had selected and began implementing before the case went to trial.

The State instead wants to offer a newly developed alternative approach to supported employment in many parts of the state without a showing that it is, again, as effective at preventing hospitalization.

The Special Master agrees that the IPS model is highly effective at reducing unnecessary hospitalization, and the State's proposed alternatives has no basis in the evidence and

no research to support its efficacy.

Finally, to peer support, sometimes the only person who has credibility is someone who has been through a similar experience. Peer support specialists bring that special expertise to bear and can provide critical support, particularly encouraging people to accept and engage in treatment.

The United States' plan provides for an expansion of peer support to all of the CMHC offices to make it accessible regardless of where you live. And this is important because some of the community mental health center regions are up to 12 counties large, and if you are expected to travel from wherever you live within that region to the one office that offers peer support, that may make that service, in reality, inaccessible.

To ensure that those core services that I've just been talking about actually get to the people who are at serious risk of hospitalization in a state hospital, the United States' plan includes provisions at the front and back doors of the hospital. Diversion provisions that are aimed to ensure that people who are in a crisis or being considered for admission to a state hospital are connected to services through mobile crisis, ACT, and all of the other services in the array. And then requirements related to discharge planning that will occur while individuals are in the state hospital, if they do have a necessary admission, and those discharge planning provisions

would ensure that they are connected to their community mental health center before they leave the hospital, that they get access to and connected to their actual provider of services like PACT and permanent supported housing before they leave, and that they have access to medication before they leave. And again, these are provisions that the United States, the Special Master, and the State largely do agree on.

Turning now to the Special Master's plan, we agree in many respects with the Special Master's conclusions. We agree that the record supports the need for appropriately tailored injunctive relief that will stop the cycle of unnecessary hospitalizations the Court identified. We agree that there are longstanding gaps between the service levels that were funded and those that were available to people with mental illness and delivered to help prevent unnecessary hospitalization.

We agree that the data on community performance is not yet adequate to assess the performance or allow the Court to determine if the requirements of the ADA are being met in light of any expansions of service the State has made. And we agree that the State's general assurances that it's in substantial compliance are insufficient.

Finally, we agree that the time for self-validation of the State's asserted reforms has long passed. The State must be held accountable to making the necessary reforms. That will only occur in an appropriately tailored remedial order ordered

by this Court.

And for those reasons, we also agree that the Court should appoint a monitor to assess the State's compliance with that ultimate order. This will give the Court a clear picture of whether the State is implementing, and it will also provide the State with clear guidance about what remains to be done before the Court can terminate the order.

To conclude, just over ten years have past since the United States opened an investigation into whether the people -- whether people in Mississippi were being unnecessarily institutionalized in state hospitals. It has been almost five years since the United States sued to enforce the Americans with Disabilities Act and ensure that people with serious mental illness in Mississippi have access to the community-based services that enable them to avoid unnecessary hospitalizations.

It has been nearly two years since this Court concluded that, in fact, the State is in violation of the ADA, and now the United States has come forth with a narrowly tailored plan to bring the state into minimum statutory compliance, and we ask that the Court order that plan.

And now Mr. Holkins has a few words about the Special Master's proposal.

THE COURT: Thank you, Ms. Fox. Mr. Holkins.

MR. HOLKINS: Good morning, Your Honor.

THE COURT: Good morning.

MR. HOLKINS: As Ms. Fox mentioned, a significant concern that we have with both the State's and the Special Master's proposals is with the substitution of unproven alternative services for PACT and IPS supported employment in large parts of the state without adequate guardrails to ensure that these alternative services are comparable or that they are as effective in preventing unnecessary institutionalization.

To be clear, the United States does not believe that the State's mental health system should be etched in stone. Our proposed remedial plan sets forth the clear standard allowing the State to implement alternative services that have comparable success at reducing hospitalization. Verifying comparability will require more data and monitoring as the Special Master acknowledged.

It would be premature to order the State to use specific alternative services without further examination and verification of the efficacy of the alternative services relative to the evidence-based models established at trial. Doing so may delay compliance with the Americans with Disabilities Act by cementing in place through the Court's order a set of untested and potentially ineffective services. The better approach is to set a clear standard of a comparable service and effectiveness in preventing unnecessary hospitalization or any alternative services.

Concerning PACT, the State proposes to meet the overwhelming unmet need for this essential service, as demonstrated at trial, by implementing two alternative services, ICORT and ICSS, in certain areas. ICORT does not have key elements of the PACT model, including integration of a prescribing clinician on the team. ICSS provided by a single clinician instead of a multi-disciplinary team is not designed for individuals with the most severe and persistent mental illnesses who meet the eligibility requirements for PACT. It is designed as a short-term service rather than an ongoing service, and the case load requirements are 1 to 20 rather than 1 to 10.

As the Special Master noted in his report, we have no evidence yet of whether either of these new services, ICORT and ICSS, will prevent unnecessary hospitalizations, as PACT does. It is simply premature to specifically incorporate these services in the order in lieu of PACT.

Again, the Court's order need not and should not etch the state's mental health system in stone, but it should hold the State accountable for providing the service that is effective in meeting the needs of people with severe and persistent mental illness, many of whom are at serious risk of experiencing repeated avoidable state hospital admissions.

Similarly, with respect to supported employment, rather than expanding IPS supported employment statewide, the State

proposed to provide limited supported employment services in many CMHC regions through a new partnership with the State's Department of Vocational Rehabilitation.

That alternative service departs from the IPS supported employment model in four key ways highlighted by the Special Master in his report. Vocational rehabilitation staff are not integrated into the individual's CMHC treatment team. The vocational rehabilitation approach does not emphasize a quick identification of skills and placement in a job. There are no requirements or expectations around the time, around the amount of time that VR staff must spend in the community providing individualized job support. And finally, vocational rehabilitation is only offered to people that staff determine to have vocational rehabilitation needs.

The State did not offer evidence establishing the effectiveness of this alternative supported employment service relative to IPS. The Special Master, as we have, emphasized the need to verify the efficacy of the State's proposed alternative services, but we differ on the legal mechanics of the Court's order.

The Special Master recommends adopting the State's proposed alternative services without a clear standard for determining comparability and without providing for any recourse if the data and monitoring show that the alternative services aren't working as intended.

As argued, it would be premature for the Court to adopt the State's alternative services when, as the Special Master has acknowledged, there is no evidence showing that these services actually work relative to the evidence-based approaches established at trial. The United States asks that the Court's order set the clear standard that the Special Master's proposal lacks, requiring that any alternative services that the State implements have comparable effectiveness at reducing hospitalizations, as do PACT and IPS supported employment. Thank you.

THE COURT: Thank you, Mr. Holkins. Hold on one second, Mr. Shelson.

(Lectern sanitized.)

THE COURT: We intended to do that between the two speakers. I apologize to you. It will be just another second. I'm getting a note pad that I forgot. Ms. Summers didn't want me having Post-It notes everywhere for my questions. She takes good care of me.

All right, Mr. Shelson.

MR. SHELSON: May I proceed, Your Honor?

THE COURT: Yes, you may.

MR. SHELSON: Your Honor, Jim Shelson for the State of Mississippi. Your Honor, injunctive relief under the law must be within appropriate limits. Mississippi's report is within appropriate limits. The plans from the DOJ and the

Special Master are not.

Ms. Fox said a couple of times that the DOJ's proposal is narrowly tailored. It is anything but narrowly tailored. As I understood what we are supposed to do now, though, Your Honor, is introduce our respective proposals to the Court. DOJ took several shots at the State's proposal. I'm going to address their proposal briefly at the end of this preliminary introduction, but I intend to save that, our criticisms of the DOJ's proposal, for oral argument at the end of today's proceedings.

Your Honor, so what is the State proposing? Ms. Fox mentioned Melodie Peet. Melodie Peet was DOJ's last witness before they rested. She's the only witness who attempted to answer the question how much is enough; in other words, what quantity of core service is sufficient to satisfy the ADA? In summary, Your Honor, Ms. Peet said baseline, and baseline being the core services in every region. Your Honor, under Mississippi's report, Mississippi will be at or above baseline within one year for every core service. Therefore, under the standard for compliance established -- well, proffered at trial by DOJ, Mississippi's report puts Mississippi in compliance with the ADA. And when you do enough to be in compliance with the ADA, you do not need to do more. DOJ's plan includes things that are more than necessary under the ADA, and they should not be part of an order.

With that said, Your Honor, the first core service I will address is intensive community services. Your Honor, Mississippi delivers intensive community services three ways: Through PACT, ICORT, which is Intensive Community Outreach and Recovery Team, and through ICSS, which is Intensive Community Support Specialists.

Your Honor, the crux of the dispute, if I may frame it, between the parties regarding intensive community services, or ICS, is whether PACT is the exclusive way ICS can be delivered appropriately. Your Honor, we submit that the trial record conclusively supports through at least three of DOJ's own experts that PACT is not the exclusive way to appropriately deliver ICS.

I will save most of that, Your Honor, for later today, but as an example, Your Honor, Your Honor may recall that Ms. Peet was, some time ago, the executive director of the Department of Mental Health in Maine. Ms. Peet testified that when she was the director, Maine had no PACT teams, no PACT teams, Your Honor, but she testified that nonetheless, Maine delivered appropriate ICS through intensive case management.

And her testimony was, and we will provide the cites to Your Honor later today, and they are in our papers, but she said that you can deliver ICS through PACT or you can deliver it through PACT and intensive case management, or ICM, or you can deliver it only through intensive case management. So this

notion that the exclusive way that PACT can be appropriately delivered by a state is through -- this notion that the only way to appropriately deliver ICS is exclusively through PACT is plainly contrary to the trial record.

So what's the point, Your Honor? We heard Your Honor two years ago. We didn't sit around and do nothing. To enhance the delivery of ICS, Mississippi developed ICORT and ICSS. ICSS, Your Honor, is the same thing as intensive case management. Mississippi calls it ICSS, so that's what I'm going to refer to it as. But Your Honor, I'm puzzled to exactly what the State -- excuse me, what DOJ wants the State to do regarding development and implementation of ICORT and ICSS.

I hope that DOJ is not suggesting that Mississippi disband its considerable efforts to design and implement ICORT and ICSS, which are now being deployed in the field.

Your Honor, on that point, Mr. Holkins talked about showing that new programs work before you put them out in the field. Your Honor, that's a catch-22. That's impossible to show. You need to deploy the program in the field to know how effectively it works. And DOJ is proposing a sort of pre-authorization thing that we will discuss more later, but that is plainly contrary to law.

And this insinuation that Mississippi is trying to replace PACT with alternative services is absolutely untrue, Your

Honor. Mississippi had eight PACT teams as of the evidentiary cutoff date of December 31, 2018. It now has ten. It's not where we are saying, oh, let us reduce the number of PACT teams, and we will have these alternative services. Your Honor, it's just the opposite. Mississippi has increased PACT since trial, plus it's added on ICORT and ICSS as additional intensive community service delivery mechanisms.

Your Honor, crisis response services, or CSUs, that's the next core service I'll discuss. Well, excuse me, Your Honor. Let me go to mobile crisis teams first. Ms. Peet said a mobile crisis team in every region. That's what Mississippi proposes. Mississippi is in line with Peet's baseline standard on mobile crisis teams. What the dispute there is, Your Honor, is DOJ is proposing a vague and unmanageable readjustment process two years after the entry of an order. In other words, they are saying start out with a mobile crisis team in each region, but two years down the road, let's look at and see if we need to enhance that service.

Your Honor, there are a series of moving targets like that in DOJ's proposal that we will point out in detail later, but those kind of moving targets that are not subject to any objective criteria for readjustment exceed the bounds of the ADA, and they are inappropriate, Your Honor, because they are not narrowly tailored, and they are standardless.

Your Honor, CSUs, again, Melodie Peet, a CSU in every

region. Mississippi's plan has CSUs in every region. The only region, as we sit here today, that doesn't have a CSU is Region 11. Mississippi's report commits to having a CSU in Region 11 within one year. The Region 15 issue, the Court heard testimony at trial that Region 15 delivers CSU services through -- in other counties, and the testimony was that's an effective way to deliver it. And the Special Master's report believes that -- found that a sufficient way to do it.

So there really isn't a dispute about the quantity of CSUs, it seems to me. I think DOJ is trying to manufacture one, quite frankly. What the dispute seems to be is more intangible things, like CSU discharge, planning procedures and so on, which, as we will show later, are not in the trial record.

Peer support services, Your Honor, the Special Master's report, I think it is paragraph 24, does a very good job of summarizing where we are on that. In brief, Your Honor, there are three ways that Mississippi delivers peer support. One is embedded, two is through Peer Bridger, and three is as a stand-alone service.

So embedded, Your Honor, is where a peer support specialist is part of a mobile team, like a mobile crisis team. And everybody agrees that on the mobile teams, there should be a peer support specialist, and there isn't -- there is. Mississippi has peer support specialists on its mobile teams.

So in other words, where peer support specialists should be embedded, they are embedded. I don't think there is any dispute about that.

Peer Bridger, I don't think there is any dispute about that either, Your Honor. The Peer Bridger program is a program that provides peer support services at the four state hospitals. The State's report and the DOJ's plan, the Special Master's plan, says have Peer Bridgers at the four state hospitals. And Mississippi will have Peer Bridgers at all the four state hospitals within one year. They already have it at -- I forget if it is two or three of them, but for whatever ones it's not at as we sit here today, it will be within one year.

So then peer support as a stand-alone service, Your Honor, here's the dispute. Mississippi says peer support specialists as a stand-alone service should be at the main office of every CMHC. DOJ says they need to be at every CMHC satellite office in the state. Two things about that, Your Honor. There's -- one, there's nothing in the trial record that supports DOJ's position. No witness, not Melodie Peet or anyone else testified that in order for the State to have sufficient peer support capacity, you -- the State must have peer support specialists at every CMHC satellite office.

The second thing, Your Honor, since that is a new position -- and it's a position the State was not able to

address at trial because we didn't know that was DOJ's position. Therefore, the State was not able to even introduce -- I don't believe it is in the record anywhere even how many satellite CMHC offices there are in Mississippi. And because of the way this has transpired, Mississippi was not able at trial to offer any evidence regarding pricing and the cost of delivering or having peer support specialists at every satellite CMHC office.

Your Honor, supported employment: Where the parties agree, and the Special Master, is that supported employment should be in every region. That's part of Peet's baseline. There's more than one way to deliver supported employment. One way is the IPS model. The other way is through -- in connection with the vocational rehabilitation. So there's IPS supported employment, and VR supported employment.

Here's the dispute, Your Honor. DOJ says the exclusive way to deliver supported employment is through the IPS model. Mississippi and I think the Special Master agree that it can be delivered through a combination of IPS and VR. So, Your Honor, we would take the position that the trial record does not support that supported employment must be exclusively delivered by the IPS model, and therefore, Mississippi should be permitted to proceed with delivering IPS through a combination -- excuse me, delivering supported employment through a combination of IPS and VR.

Housing, Your Honor, DOJ keeps citing the -- what the State said it needs as far as housing. What DOJ is referring to is one individual many years ago said that -- gave the number of 2600 housing vouchers. In the stipulations, the parties stipulated that that individual did, in fact, say that. There is no stipulation or admission whatsoever from the State that that number -- that that estimate is accurate. In fact, Your Honor, there is nothing in the record which -- which sets a standard for even how you determine the sufficiency of housing vouchers.

So there's two approaches to this, Your Honor. The DOJ and Special Master over time increase the number of housing vouchers the State may have, so I think by year 3 after the order under DOJ's proposal, Mississippi would have to have 750 additional housing vouchers. And I think it is year 2 after the order, under the Special Master's proposal, it would be 500 additional housing vouchers.

So, Your Honor, the math is in the record. It's that housing voucher costs about $8,000 a year. So the Court can do the math. However many -- if it is done by the number of housing vouchers, it is 8,000 per voucher. So 750 times $8,000 per voucher, for example, that's $6 million a year going forward in perpetuity, which, as we will argue later, has, among other things, fundamental alteration implications.

But the other way to do housing vouchers, Your Honor, is

through a sum certain of money, and that's what Mississippi proposes. So we are in fiscal year '22 now. Mississippi has increased its budget for housing vouchers in this fiscal year by $400,000.

The reason why, Your Honor, we say it is better to do it by a sum certain than by an arbitrary quantity of housing vouchers is two-fold. First, different people use housing vouchers for different periods of time. Somebody may use one for a month. Somebody may use one for 15 months. So once you set -- once you do it by a quantity of housing vouchers, you are locked in, regardless of how long a person may or may not need -- may or may not need the housing voucher.

And that brings us to the second component of that, Your Honor. If you -- there's nothing in the record that suggests to the Court how to measure the quantity of housing vouchers Mississippi should have, and it's not because the parties did not want to give that information to the Court. It's just there's no recognized way in the literature to make that calculation, and that's why no one has done it.

But anyway, Your Honor, if you set a quantitative threshold, let's say it's 750 per year, what happens if you get three or four years down the road, and you just don't need that many? It's just not a smart public policy way to manage that issue.

Your Honor, that's Mississippi's plan in a nutshell. But

let me turn briefly to DOJ's plan. DOJ's plan exceeds the appropriate limits of injunctive relief for at least five reasons. First, as I've already mentioned and Ms. Fox has mentioned, DOJ's expert, Melodie Peet, proffered a baseline for the quantity of the core services she believes Mississippi should have, but DOJ's plan exceeds Peet's baseline standard and would require Mississippi to do more than is necessary to comply with the ADA.

Second, Your Honor, DOJ talks an awful lot about accountability, but DOJ's plan does not contain a single performance measure to assess accountability. Your Honor, as Ms. Fox pointed out, we are five years almost after filing of the lawsuit, two years after the conclusion of the trial, after DOJ rested, and they talk about accountability, but they won't and have not proposed a single measure to assess accountability in their plan.

That's amazing to us because Ms. Fox and Mr. Holkins talked about clear standards. There are not clear standards in DOJ's report or plan, and that's part of the problem with it. Your Honor asked some time ago how to measure success. DOJ's proposal does not even attempt to answer that question. Instead, Your Honor, there's a series of moving targets that are subject to adjustment over time that are tied to no objective criteria. And we submit, Your Honor, that any order that allows that exceeds the appropriate limits of an

injunction.

What's more, Your Honor, is DOJ established the Peet baseline standard. They own that standard. They can't move the goal line now, but they sure are trying to.

The third thing, Your Honor, is that DOJ said there should be an implementation plan, but they failed to propose one.

The fourth thing is DOJ said there should be a monitor, but they failed to address the monitor's duties, compensation and authority. Your Honor, we fundamentally believe that no issues at this point should be deferred. The time for complete relief is now. If DOJ wants these things, they needed to come forward with their specific proposal. They haven't. Therefore, they should not be afforded relief in terms of an implementation plan or a monitor.

Fifth, Your Honor, DOJ's proposed termination provision is impossible to satisfy. It contains no objective criteria for termination, so Mississippi cannot know what it must do to terminate the order.

Your Honor, that's a formula for a perpetual order because it provides no objective way out for the State of Mississippi. We submit, Your Honor, that a perpetual order is not in the best interest of anyone, especially people with SMI in Mississippi.

Your Honor, the Special Master's report -- the Special Master's plan contains some of those same flaws, which again,

we hope to address in more detail when we get to the oral argument phase of this proceeding. So subject to any questions, Your Honor, that concludes my preliminary presentation.

THE COURT: Thank you, Mr. Shelson.

Okay. The Court is ready to hear from the Special Master. You will be here awhile, so you can take the witness stand. I assume you will be here awhile.

(OATH ADMINISTERED)

DR. MICHAEL HOGAN,

having first been duly sworn, testified as follows:

EXAMINATION

BY THE COURT:

Q. Dr. Hogan, thank you for your service. I want to say that first. We appreciate all the work that you've done to bring us to this point where we are. I'm going to just allow you to tell us, give us the benefit of your background, first of all, because, again, the public, I think, needs to know in part why you were the appropriate person, if you will, other than the fact that I appointed you, that you were the appropriate person to take on this task.

Tell us what you believe your role was and what you did to complete your report. And I know that the United States has presented a proposal post hearing on how the Court should proceed. The State of Mississippi post hearing submitted its

report. And I know after those two reports were submitted, throughout the course of the process, you've met with the State, you've met with the United States, and you've made a detailed report concerning -- after having evaluated each of those reports, you've made a report and a recommendation to the Court that the parties now have had an opportunity to respond to. So again, for the benefit of the record, could you tell us who you are, Dr. Hogan.

A. Thank you, Your Honor. My name is Michael Hogan, and I came to this through a long journey, professional and personal related to mental health. I started my career in mental health, I hate to confess it, over 40 years ago as the manager of mental health services in western Massachusetts, which was an unusual circumstance because at that point in time, that region of Massachusetts was under a federal court consent decree that predated but was very similar to *Olmstead* to develop community services to eventually replace the state hospital with alternative services. So I served there for several years.

I got thrown out, not related to my performance, I think. It was political. I went to Connecticut and served a couple of years as deputy commissioner and then three and a half years as commissioner. There was a gubernatorial succession. It looked like an appropriate time to move on. I went to Ohio and served for 16 years as director of mental health for that state. And

then again, in the context of another gubernatorial transition, I went back to my home state, which was New York, and served about six years there, which was about as long as I could take it.

And along the way, I've also had a number of other opportunities. I chaired President George Bush's President's Commission on Mental Health in 2003, served nine years on the board of the Joint Commission as the first representative of the behavioral health field, and served two terms on the advisory council for the National Institute of Mental Health.

And Your Honor, I also have had other experiences. About the same time I started in the field professionally, my kid sister developed schizophrenia. So as I've walked my journey, she has walked hers. I've stayed close to her during that time, but I've seen the best and the worst of what mental health services can do. She is doing very well now. I'm her chauffeur and banker, and she is my conscience.

I have also had others in my family come in contact with mental health services much more recently in the context of a crisis where the police responded. There was no mobile crisis team, and there was an arrest, and this person spent 48 hours psychotic in a jail cell until I was able to get there. So I've come at this from the basis of lots of experience in lots of places.

As Your Honor and the parties know, you appointed me I

think in February of last year initially to essentially serve as a mediator between the parties. We spent a lot of time in conversations. I would say those conversations were -- the parties were both energetically committed to seeking a shared solution, but ultimately, at the end of the day, we weren't able to achieve one. So that experience taught me a lot, but as Your Honor and as the attorneys know, those conversations that take place in the context of seeking a settlement agreement are not part of the record. They are not really for consideration as the Court goes forward because they were confidential negotiations.

So all of that means that my direct knowledge of services in Mississippi is limited. I've certainly read Your Honor's opinion and read a lot of the trial material and have had feedback about that from the attorneys, but my direct experiences -- so I've seen a lot in a lot of places, but I haven't seen what's on the ground here.

I will say from my experience, and this is not at issue in this case, but the reality is that most people with serious mental illness get by without using these core services. They might be hospitalized every once in a while. They go to a mental health center or a clinic for counseling and medication treatment, and they get on with their lives, for better or for ill. And those services in basic out-patient services, they are not really at play. Mississippi provides those services

largely through its network of community mental health centers. The quality of out-patient services is not at issue here, but it's very important. Can you get in? Can you have a good relationship with the prescriber or therapist who is taking care of you? So the focus here is on the core services the parties have agreed to that represent, in a sense, the intensive services for people with the most substantial mental health problems.

It appears, from what I can see, that there have been significant improvements over time in Mississippi and that there is some quality that exists in those services. The CMHC approach is kind of a good fundamental approach to provide community services because it assures a point in every service area for care. That's something, for example, that's lacking in New York, where there are thousands of providers, but nobody knows at the ground level who is in charge. But CMHCs are also variable. They are similarly autonomous. The State has very detailed regulations for its services, but the overall performance is variable.

The State has added many services, at least in the context of this case, and they've all been discussed here. From my perspective, and one of the things I've been focused on in the last few years, I've had a chance, since I left New York state employ, to work on things I never could get done when I was allegedly in charge, and so I have spent a good deal of time

working on crisis care around the country. Mississippi's approach to crisis care is not perfect, but it's good. It's better than the average states, although some performance problems appear to exist. So there's good in the system, and there's been improvement.

The core issue that I am confounded by and that I think confronts the Court has to do with the fact that the performance of those services on the ground is uncertain. Maybe the people providing the services know, maybe the Department of Mental Health knows, more or less, but I can't see -- I don't know, and I don't think the Court knows, and the evidence at trial was clear that there were gaps between funded capacity and actual capacity, and that there were consequences of those gaps and those problems.

So it seems to me that this is a paradox, finding some way for the Court to be assured of the actual performance on the ground. As the Court said in its opinion and order, a way to measure progress going forward is actually -- it's not a burden. It's the way to get out of this case. And I will speak more to that as I go on and try to address a way to measure performance that is -- that ought to be, frankly, embraced by the State because it's a more timely way to get out of this than any other way.

I've looked at and the State has pretty good -- exemplary, I would say, operational standards for service types. It has

detailed regulations for buildings and square footage and toilets and so on. Those standards are very solid, very detailed, they go into more detail than I've seen in many places, but I haven't seen overall standards of the performance of mental health centers. So in a sense, the parts are good, the way the services are defined are good, that was established at trial, but outcomes are not clear, and performance expectations.

A positive but also a challenge in Mississippi is that Medicaid is the major payor for community mental health services and for hospital services as well, except in state hospitals, but it's not clear to me that mental health is the Division of Medicaid's forte. It hasn't been in places that I have been. And it's unclear how the Division of Medicaid or the Department of Mental Health work together on this.

And DMH has not had -- it says in its report that it will have in the next year individual data on the services that it funds, and the DMH provides the, in a sense, the core funding for the core services. And so there's a gap there with respect to knowledge about the performance of those services.

And so it seems to me that all of these issues create sort of three fundamental choices in terms of how to think about the performance of the mental health system. You can ignore it, you can micromanage it, or you can set expectations for the State and then measure that those expectations have been met.

And that's the approach that I recommend.

From that very general background, Your Honor, I will just describe in a little bit of detail the report that I submitted to the Court following the recommendations, the report of the State, and the proposals of the United States.

So I submitted a twenty or so page single-spaced report to the Court in three sections. The first section was, frankly, kind of boilerplate. It covered the background of the case and was derived entirely from the reports of the State and of the United States.

In the middle section of the report, I tried to describe what I thought was at play or of significance. My perspective on the issues that were -- that are being considered here, including trying to identify and speak to the impact of each kind of core service on people living with serious mental illness, from my own experience, and then that perspective, at the end of the day, plus my experiences, led to, in a sense, the framework that I applied in the last section of the report, which was elements of an order that Your Honor may wish to enter.

Without going on too much, but in trying to respond to Your Honor's charge, let me just say -- speak a little bit to my approach to these issues that I think is laid out in my report, but if people have not had a chance to read it.

So the recommendations, I think, in the State's report and

in what the U.S. government has proposed are both substantive. I think the right approach or solution can be found generally, from my view, either in the State or the DOJ's proposal or in an approach that considers the merits of each and finds a common ground, and that's what I've tried to do.

As Your Honor knows, and as the parties I think are painfully aware, I'm not an attorney, and so I'm not grounded in the legalities here, but I do understand that it is important to try to ground the recommendations in the trial record. So I've tried to do that to the extent of my ability.

There are some areas where it's not quite possible to do that. For example, and this is an irony, because the State wants the trial record clearly to serve as the foundation, but the State has developed alternative intensive community services, as Ms. Fox and Mr. Shelson and Mr. Holkins have already described, that I end up supporting, they seem to be sensible to me, but they are not really supported in the trial record. So there's an irony there, but it seems to me that if the services that are recommended are thoughtful, if they are put in place carefully, if they are consistent with the broader evidence and the common sense -- and common sense, that doesn't necessarily disqualify them from implementation.

As I've already said, it seems to me that the actual measured performance of the state's community mental health system is the central issue in resolving this case, and the

trial record shows gaps between, as I said before, funded capacity and services actually received, and then the trial record also demonstrates that there are circumstances where, for example, with respect to mobile crisis services, the State's operational standards, which as I understand them are regulations with the force of law --

THE COURT: Slow down, please.

A. I'm sorry. Yes. The recommendations about the timeliness of mobile crisis service are not being met, and so this issue of performance, it seems to me, is central to the case.

A complicated and sensitive area is that I don't believe the record demonstrates, and my perspective is that it's not clear that the State has the capacity to adequately oversee the community mental health centers on their overall performance, and I say that knowing that it's a very difficult task. These are --

THE COURT: Hold on for one second.

A. So the community mental health centers are local organizations. They are chartered under state law. They have local governance, but they receive state funds. They bill Medicaid for services. It seems to me, from what I've been able to pick up, that there have been periodic problems with community mental health center performance. One of them I think failed and was taken over by -- services were taken over by somebody else. And so this is a -- a complicated area that

needs to be carefully attended to.

The community mental health centers are complicated organizations. They are far more complicated than most businesses of the same size because their product line is diverse, their funding is uncertain, their customers are -- have various challenges of their own. So this is a -- this is a challenging issue.

Q. Dr. Hogan, let me interrupt you. Again, for the purposes of not only the record but those who are listening and hearing, observing, and the parties will be able to tell me, because I heard testimony on it, but do you recollect how our community mental health services are formed, who sits on them, and, you know, what are they specifically tasked with? I mean, the parties will be able to tell me that, but if you have that information now, if you recall from your review, could you explain it a little bit?

A. Thank you, Your Honor. I've said a little bit about that. I mean, the community mental health centers originated with President Kennedy's legislation in 1963 that sought to -- it was one of the first salvos, I guess, in this effort to redirect care from not very much, or too much, that is, no services or having to go to a hospital, by providing community alternatives, and that Community Mental Health Center Act, as I said, passed in 1963, envisioned a network of community mental health centers around the country. These would primarily be

local entities. There are some states, for example, South Carolina, I believe the State Department of Mental Health actually operates the community mental health centers.

I'm not sure precisely what the status of the community mental health centers here is because I looked at this in the statutes and regulations but wasn't clear. I think they are nonprofit organizations with special responsibilities established in state statute. But mostly around the country, the community mental health centers are nonprofit organizations. They are each responsible for a chunk of territory involving multiple counties. The regions are quite variable in size and geography and personality, but the community mental health center in each region has the franchise, in effect.

And the services that they provide are partly paid by grants or contracts from the Department of Mental Health for particularly the core services that are involved here. So those grants or contracts are issued with detailed specifications from the Department of Mental Health. The operational standards for each describe in considerable detail the way that particular service, for example, a PACT team, is supposed to operate.

When the State deems and the Department of Mental Health deems that a service has met its operational standards, then if that service is included in the state's Medicaid plan, the

community mental health center can bill the Division of Medicaid for that service.

The community mental health centers have a local governance board. I believe, but I'm not a hundred percent certain, that local officials are responsible for appointing the members of that board. There are audit and accountability requirements on the financial side that look to me to be pretty solid. These are different operational standards of the Department of Mental Health.

So I think those, Your Honor, are the key elements. The community mental health center is the core entity in each region. They have overall accountability. They operate most of the services. The Department of Mental Health could contract with other entities, but for the core services, I believe it contracts with the community mental health centers. So they are the show in any given community. That's about as far, Your Honor, as I can take that.

Q. Thank you.

A. So in a sense, you might say in a way, it's like a school district, although it doesn't operate under quite the degree of statute and accountability that a school district would. It's not necessarily a public entity.

So moving on, my reading of the progress that the state has made and my own long experience as a state official and as a defendant in court cases makes me sympathetic to the need of

state officials to chart and implement directions that will resolve the issues that are at play in this case, as well as secure reasonable operation of the mental health center overall.

And as has already been noted, there are several broad areas where the parties differ about what that approach should be, the area of Intensive Community Support Services, and also how to best deliver supported employment services. So I thought about that quite a bit and went through the logic for that before coming to my recommendations, so let me turn to that issue now.

I point out, and this is partly to get at this question as to what is, quote-unquote, evidence-based services, and how do we come up with something that is evidence-based. And I illustrated that in part through a story about how the PACT emerged as an evidence-based service.

The very first PACT team was established in Wisconsin by leaders there who -- in the state hospital who observed that there were people with serious mental illness who did very well when they were in the hospital, but they did very poorly when they were discharged to the community, and it led them to conclude that it wasn't the people. It must have been something about the way that things were constructed. And they also observed that although people did well while they were in the hospital, they really didn't seem to require that extensive

or restrictive level of care. So, in essence, they moved the treatment team from a state hospital unit into the community with its patients, and their logic in doing this was to try to repeat those things that were characteristic of the services in the state hospital in the community.

To illustrate that, I visited many years ago the mental health center in Madison, Wisconsin and asked to see the office of their assertive community treatment team, and so the guy showing me around said, "Well, I'll show you, but there's nobody here." So we go into the place that is their office, and it was a large room, about half the size of this courtroom, with chairs around the outside, and over here there's a Dutch door, and that's it. Nobody is there. This guy says, "Well, do you know what's behind the Dutch door?" And I said, "I think that's the nursing station and probably where the meds are." And he says, "That's right." And he says, "Do you know what the boundaries of the unit are?" And I said, "I think I'm getting what you are saying. I think the boundaries of the unit are the county." He said, "That's right. And so we think of ourselves as an in-patient unit, but it's really an outpatient unit, and our patients, our clients are out there, and we try to do those things that were determined to be necessary in the state hospital and effective here, that is, we are available to our people 24/7. We cover two shifts a day with our staffing, but we are available at any time, because

problems could come up at any time. We are very assertive in our approach to care. We are on people like white on rice. We try to be very nice and develop relationships with them. You have to keep in mind that this was years ago before we knew what we know now."

He said, "One of the things that we do is, you know, behind the door where the meds are, there are also cigarettes, and if people want their cigarettes, they come and they get their meds." Today we'd recoil properly from that. But they were comfortable with using influence and leverage, as well as relationships.

They maintain on the PACT standards to this day the essential configurations of an in-patient unit, although most PACT teams have now evolved, and I think this is true in the Mississippi operational standards, to include several kinds of staffing that aren't that relevant in a hospital but are very relevant in the community, that is, the ability to deal with substance misuse issues, having at least one peer on the team so that people have the opportunity to relate to someone who has been down the road that they are on, and an employment specialist, because we have learned since then that employment is often critical in recovery.

So the thing that was the most unusual about this first PACT team in Wisconsin, I mean, it was a very innovative approach, but what was just as unusual was the fact that it

was implemented originally -- this was the second PACT team -- in a randomized control trial, which means they took a number of people with serious mental illness who had all qualified for PACT services, and half of them, on a random basis, got assigned to the PACT team, and half of them, on a random basis, got assigned to what is euphemistically known as usual care, which, like, means you get a referral, and who knows what happens? But you get a referral to the mental health center, maybe you get meds, maybe you get therapy, maybe you don't go, et cetera, et cetera. And then both services ran for some period of time, and then the data was looked at independently. And the data showed that the PACT approach was far better particularly reducing hospitalization and rehospitalization. There were a number of other benefits as well, but that was the core thing that the researchers were looking at.

So we had, for the first time, with respect to PACT services, and this is going back to, like, 1979, a gold standard. Before, we had opinion. It was credible opinion, but now we had a gold standard. So that approach has now been replicated for a number of other community services, like supported employment.

For most of my career, certainly going all the way back to Massachusetts in about 1980, we didn't have evidence-based services, so we had to do the best that we could with the knowledge that we had. The evidence, the research has lagged

behind the art of providing care, which has always been a frustration of mine, but by the same token, the evidence is also clear from PACT, from supported employment, from supported housing, from a lot of other services, that the outcomes are better when you do it the right way. That implies that the right way has to be measured, and so these services all have what are called fidelity measures. And fidelity is just, are you doing it the way you are supposed to be doing it.

This is also important, if I may be permitted another yarn from my own experience, when I was in Connecticut, we implemented assertive community treatment teams. This was just a few years after the evidence had come out in Wisconsin. One of them was in the mental health center that Ms. Peet was actually running at the time. One of them was at an out-patient service that we created in Middletown, which was where the original state hospital was, but ironically, they had lousy community services. So we created an out-patient program run by the state hospital and created a PACT team and a crisis team as a part of that.

For the PACT team, we had Dr. Lynnee Stein, who was the developer of PACT, come and train the staff, and we, in fact, hired his chief resident from the year before, who had been the medical director of a PACT team in Wisconsin. We hired her as the medical director of the PACT team in Middletown. So I kind of thought we had died and gone to heaven, and everything was

hunky-dory. At some time later, I'm coming in in the morning and I see my research director going out the back door, and I said, "What's up? Where are you headed to?" And she said, "I'm going down to Middletown." I said, "What are you doing?" And she said, "I'm going to do a fidelity assessment for the PACT team." And my reaction was, "Why do you have to do that? I mean, we hired the master student. The master trained the staff." And she sort of smiled at me indulgently and said, "Well, we will see." And I saw her next a few days ago, and I said, "How did that PACT do?" She said, "Not so great. They were not meeting with people every day. They were having people come to the office instead of going to them," et cetera, et cetera, et cetera.

So this issue of what constitutes an evidence-based service is important, and measuring that it's being done according to Hoyle is also important. So there are several areas in my report where I suggest that the State should measure fidelity in a similar way where those measures exist or where they might be applied.

So given all of that, and considering intensive community services first, the government's -- U.S. government's approach and the State's approach, basically I come down on the State's approach with the caveat, which I think is a pretty big caveat, that there needs to be accountability and measurement of the fidelity of these services.

So ICORT is not an evidence-based service, but it's a very reasonable adaptation of PACT for smaller rural communities. It departs from PACT with respect to some of the requirements, that is, having a doc who is actually on the team. The doc is in the mental health center. So that might create a small issue in many places. But it has some of the same elements as PACT built in in terms of the staffing and the expectation that people are seeing frequently and a low case load and so on. So this is a service that has been kind of mini-PACT team. It has been implemented in a number of other states, and it seems to me that it's what I would describe as a very reasonable accommodation in more dispersed areas, but it would make a lot more sense if the State came up with a measure of fidelity of ICORT to its standards and then measured that with some regularity.

The third approach that the State proposes for intensive community services, the ICSS, nobody would assert that that was equivalent to PACT, but I would say it is a not unreasonable approach for very rural areas. PACT isn't going to work that well in these very rural areas anyway unless you have much lower case loads and the cost per service is proportionally much, much higher.

So I think that it is a reasonable accommodation, but I also believe that its outcomes need to be assessed. That is one of the things that I believe the State should do is look at

the levels of state hospitalization that ensue from each community mental health center and the number of state hospital admissions and readmissions that ensue, and that they should have some kind of an approach for that, and they might need to modify various kinds of services, including ICSS, if it's turning out that the performance is not -- not up to those standards. So I think it is -- what the State has proposed is a reasonable alternative if it is measured appropriately.

I also note that the State has, as Mr. Shelson said, has already implemented these services, or says that it has. We don't have any independent validation of that, but the State says that it has, and the capacity of the total intensive services that the State proposes would be substantially greater than the capacity of the PACT teams that the federal government approaches, although certainly with the federal government's approach, over time you would catch up. Anyway, the alternative approach that the State proposes for Intensive Community Support Services is a reasonable alternative.

With respect to supported employment services, I kind of conclude the same thing, although it is a little bit of a stretch. The individual placement with support, or IPS, has got a very clear evidence base. It's more effective than any other approach used. I, myself, have implemented approaches something like the vocational rehabilitation approach that the State proposes to use. It works better than nothing at all

because at least you have somebody focusing on work. And therapists don't necessarily focus on work. And docs, prescribers, don't necessarily focus on work. They have other tasks, but then it turns out that work is the way that many people maintain their life.

My kid sister at one point had just gotten out of a state hospital, and she got a job in a call center. It wasn't a great job, but she was doing it. And then she got another job. I can't remember what it was, working Friday and Saturday nights. I said to her, "Do you think you really need this? Is that going to be too stressful to be doing all of this at once?" And she said to me kindly, essentially, "You idiot. When do you think I get in trouble?" And she got in trouble on Friday and Saturday nights. So she was taking steps to put herself in a better place in these times when she got in trouble.

So my suggestion is that the State's approach be supported, but I also suggest that the State should identify a few of what I would describe as the active ingredients for IPS and apply them to the services that are operated in partnership with vocational rehabilitation. For example, one of the standard approaches in many vocational rehabilitation programs is people are referred who are good candidates, quote-unquote, good candidates for employment, but it turns out that some good candidates for employment don't look like good candidates.

They are just really good workers. And they might be very ill, they might even be actively psychotic, but they are good workers nonetheless. So that approach of allowing any person with serious mental illness in the mental health center to have access to employment services I think is one of the things that I would suggest be part of sort of a short fidelity, alternative fidelity scale for these services.

Turning to crisis services, as has been said, there's not much disagreement among the parties with respect to crisis residential services. I think that having access to that alternative service in the small region, I think it's Region 15, seems to be working okay. I think the State should continue to manage that.

The approach -- one of the areas where I have, in a sense, some concerns with my own report, but I'm going to stand by it, is in recommendation with respect to mobile crisis services. And the recommendation is that the State keep in place what it has and that it measure the performance of mobile crisis services in terms of timeliness of access, and that it take the action that it deems necessary if the timeliness of action isn't there.

I find it hard to believe that sustained performance that does not meet the State's own regulation would be acceptable, but I don't believe that we need the Court to review that. So that's just my own opinion. It gives me -- you know, I have

some qualms with it because the reports, for example, from the sheriff and from other people who testified that they weren't able to get mobile crisis services is a concern, but the State's approach to crisis services is overall pretty good. I think its standards are pretty clear, and I think it should be accountable and responsible through any means to meet its own regulations.

Peer support services, there's not a -- there's this general agreement, and I appreciate Mr. Shelson's description of how peer support services work. I think it's important to note that embedding peer support specialists in these high intensity services, that's the way I would describe them, mobile crisis services and intensive community support services, the State has put peers in the places, as well as the Peer Bridger in the state hospital, they have put them in the places where people are most likely to need these services, that is, when they are troubled, they are in extremis, they may not be accepting services yet, and a relationship, a nonthreatening relationship with somebody who is not, quote, a mental health professional, may be very valuable in encouraging their participation. So the State's own approach demonstrates that.

Beyond those approaches, the third approach, which is having peer support services, as Mr. Shelson has described it, as a free-standing service in the mental health centers is a

good priority. So I suggest that the State ought to look at not necessarily all of its out-patient clinics, because a lot of them are small. There are a lot of them in the state. It's not clear on all the community mental health center websites, but I looked at a bunch of them. Some of the community mental health centers have out-patient satellites in every county; some of them don't. So I think the State should be accountable for deciding where it should station, and this is not necessarily a new appropriation. It might redeploy perhaps for a day a week or two days a week some peer specialists to other out-patient clinic operations, especially ones that are five days a week, and at appropriate times. So I think the State should be accountable to accomplish that. I don't feel like I have enough knowledge to say how the line ought to be drawn.

With respect to supported housing, that is the biggest service area where there is a substantial agreement between the parties, and it's a very tough issue. I talked a little bit in my report about the essential nature of having safe, decent and affordable housing for people living with serious mental illness. The best way to get safe, decent and affordable housing is through permanent supported housing, but there are other ways to get it as well. I mean, you might be lucky. The mental health center might have a housing coordinator who is on the phone and maintains relationships with landlords and knows who the landlords are and where the apartments are that are

affordable but decent and help you to get in there.

There are cheap approaches to support housing that are used in many places, but it's not clear to me that they are used here. Those would include a smaller subsidy or a time-limited subsidy, for example, that would pay the security deposit and the first month's rent for somebody to get into an apartment and maybe help them set it up, but then they would be on their own after that. So some states use that approach.

The State of Arizona has just applied for -- as a part of its Medicaid plan, to have a time-limited service like that be available for people in crisis as a part of -- as a part of Medicaid.

There are a number of states that have engaged in a partnership with their state and local housing agencies to set aside Section 8 federal housing subsidies for qualifying people with a serious mental illness. So the dilemma for me, looking at supported housing is, supported housing is the Cadillac way to get housing, but it's not the only way. Like, you know, there's a Buick and a Ford and a Yugo approach to supported housing as well. I don't see evidence that the State is using those other approaches. On the other hand, the State established this supported housing approach and funds it at a very low level, at a much lower level than most states, from my experience, use.

So what does one do under those circumstances? Having

safe, decent and affordable housing is crucial. I can remember times when I have pulled my sister out of places that she had gotten into after getting out of the state hospital that a human being shouldn't be living in. There is not much doubt that in some of those circumstances, that contributed to her decompensation and readmission. So there's got to be some approach, it seems to me.

And so why did I recommend what I did, which was somewhere close to what the Department of Justice recommends but considerably more than Mississippi's approach? It seems to me that by establishing that approach and funding it, Mississippi has said it is the right thing to do. I can't see, but it's not available for enough individuals. And the most concrete evidence of that, there's this random guy's testimony at trial, I don't know about that, but the evidence from the federal government's review of 154 individuals is that 74 of them, I think the record was, would have benefited from supported housing. So this is a robust service that is critical for the people most at risk.

The State departs from the usual model of permanent supported housing by having its CHOICE program not necessarily be permanent, which I guess, you know, that might not be ideal. Purists in the supported housing world wouldn't find it is ideal, but it looks to me like the procedures for helping people transition off that voucher into alternative housing are

not unreasonable procedures, so the number of slots that are funded is going to serve more people over the course of the year than the number of slots, because some people would transition.

So that is why I end up with the approach that I recommended. You know, in a sense, I would rather have the State do a number of other things, like have housing coordinators at community mental health centers, like have smaller subsidies, like work on Section 8 and do a bunch of other things that wouldn't cost that much money. But they don't appear to be happening, and so I sort of fall back on the approach which has proven to work, which is supported housing, and recommend a substantial expansion of capacity there.

There's a small issue of medication assistance. Some people need medications. They are not on Medicaid or some other insurance. They don't have any way to pay for them. And having to switch medication, particularly if you have been in the hospital, you have been started on something and you get out and you can't get it in the community is a -- it's a frequent cause of decompensation and readmission.

So continuity is important. And the parties agree on a small fund that would be provided by the State to assure continuity of medication treatment. The State proposes to have it for a couple of years. The federal government approach recommends that it be a permanent approach. My approach is

that you ought to have it for a couple of years and then keep it unless it turns out the data suggests you don't need it.

There are not substantial differences, in my view, in what the Department of Justice or the State approach is with respect to state hospital discharge planning. The recommendations are pretty common sense. I really commend the State for its starting up a Peer Bridger program, which appears at the state hospital that can help people make the connection back to community.

This is not a trivial matter in that connections back to community care are -- they are actually better in state systems than they are in the rest of the world. But on a national basis, there's a recommended standard for health care programs, and the standard is that people being discharged from a psychiatric hospital or a psychiatric unit would keep at least one appointment on an out-patient basis within a week of being discharged, with the second one within a month. And the performance on that standard nationally is worse than the performance of any other standard in this health data set that is called HEDIS, health effectiveness something or other.

So the performance is pretty horrible, but it is particularly important for psychiatric hospitals, and it's particularly important for state hospitals, which are more likely to have individuals with the greatest need. But using every means possible to try to make sure that people stay

engaged in care is a really important idea, and I think the Peer Bridger approach to meet with people before they are discharged to have a little bit of a relationship, saying, "This worked for me, I think it ought to work for you," is a good idea.

I guess the last thing that I will -- two other things, I guess. One is this question of an implementation plan. The Department of Justice proposes there be a detailed implementation plan. My recommendation is that there be an implementation plan, but most of its focus should be on tying up the loose ends of data and reporting that would be sufficient in the end to, as the Court said, measure success along the way. I don't think there needs to be an implementation plan for the services that the State already has put in place. There can just be a demonstration that the services are in place.

I would -- in my report, I recommend that the State consult with the Federal Government and with the monitor, if there is one, on the criteria for that implementation plan but that it be within the State's authority to define what is in that plan.

So the implementation plan is, for me, the answer to Mr. Shelson's question about what are the exit criteria. The State ought to define what it proposes those exit criteria to be, what is the measure to be used for fidelity, what would be an

acceptable score for fidelity. The State ought to sort of lay that out, and the federal government can object if it wishes. I would expect the State to be somewhat forthcoming in negotiating on those issues and then, at the end of the day, to submit it to the Court. It is kind of a tough standard to suggest that if, at the end of the day, the Department of Justice isn't satisfied, they would raise that with the Court, but I would rather go that way than to tie the State's hands.

So in a sense, from that perspective, defining the criteria would be primarily the State's job. Defining whether the State has met those criteria is ultimately the Court's job, in my view.

I also -- it's sort of a minor thing, but I think it's significant, is that in terms of termination of the case, I recommend that the State be allowed to propose that it's met compliance with these standards, again, a lot of which it would have defined, on a section-by-section basis. So if the State would say, we've done this with respect to the medication provision, and we commit to continuing to do it, so we want to be found in compliance with that, and then the monitor, if there is one, and the Court could determine that, as opposed to having to cross every T and dot every I before exit.

I think, Your Honor, with that -- I don't know whether I've gone on too long or not enough, but I'm feeling like maybe a little bit on the too-long side, but I think on that, I will

rest and try to respond to any questions that you have and then to the parties.

THE COURT: Thank you. Thank you, Dr. Hogan. At this time, for the court reporter's purposes, we are going to take a 15-minute break for the court reporter. I will have just a couple of questions, Dr. Hogan, and then I will allow the United States to present whatever questions it has, and then followed by the State of Mississippi, and if necessary, the United States for rebuttal purposes. But at this time, we are going to take a 15-minute recess. So we are -- we are in recess.

(RECESS TAKEN AT 10:56 A.M. UNTIL 11:07 A.M.).

THE COURT: Are we ready to start back up? I see the Lieutenant Governor is not here. He may have other duties, I figure, than sitting here in the courtroom all day.

MR. SHELSON: Your Honor, Jim Shelson. He does have other duties.

BY THE COURT:

Q. All right. Dr. Hogan, I have just a couple of questions, and I'm going to give the parties the opportunity to explore with you what they believe might be the best approach to these things.

You know, I know the record is, like, two years old now. We had the trial a couple of years ago. And a lot of figures came out about costs, and one cost that has sort of been

focused on today is the housing stuff.

But overall, based on your review of the record and your knowledge of it, of these matters, there is not necessarily a fixed cost, but there is an overall cost that the State of Mississippi is devoting to its mental health services. To the extent that there might be based on either your recommendation or the recommendation of the United States or even the recommendation of the State of Mississippi, if there is more money put in on the community health side systems or community-based systems and you increase that, I guess, in a sense, that would suggest that there would be -- that the overall cost would not necessarily be increased, because if you have more money going into community-based treatment, that suggests at least that you might have -- that monies that would have ordinarily been going into hospitalizations and other things would decrease. Is that a fair statement?

A. Thank you, Your Honor. It's a conundrum, and I wish I could give you a simple answer for it. It is generally true that the community services cost less on a daily basis or a visit basis than hospital services because a hospital is a 24/7 rigorously staffed enterprise, so community services cost less per unit of service. On the other hand, when you invest in them, the overall costs go up, and then to some extent, those costs may come down if they result in less state hospital use.

And there's another dimension in this equation, which is

that -- and Mississippi has partially taken advantage of this, and that is, if services are paid via Medicaid, then under agreement between the federal government and the states, a substantial portion of those costs is paid by the federal government.

So Medicaid -- or Mississippi has been, I would say, reasonably generous about including its community mental health services in Medicaid, and that has -- that means that far more of the mental health expenditure in the state is paid by Medicaid than paid by the Department of Mental Health, but that is reimbursed about 77 percent by the federal government. So in a sense, that reduces the net cost to the state.

So I think those are the -- those are the major elements of that equation, if you will. I do -- I don't have all the data, but I do believe that the State has reduced expenditures in the state hospitals as a result of decreased use, and I believe the State has also -- and I don't have the details on this, but looking at what I've seen, it looks like the State has consolidated administrative services so several of the state hospitals share administration, which has resulted in less expenditure. So those -- those are -- those offsets, particularly which took place I think about three years ago, led to substantial expansion, or the funds -- the savings were used by the State to substantially expand some of the services that are in question here, but I don't know the details of all

of that.

And I guess as an editorial or to ask -- to answer a question that Your Honor didn't ask, it seems that setting aside a few differences that still exist between the parties, and setting aside the question of the overall performance of the mental health centers, that at a gross level, the state is approaching an equilibrium with respect to its balance of community services and state hospital. It is not grossly out of balance anymore. It is approaching an equilibrium, and there are probably a few areas where investments or improvements are needed but they're probably not of the scope that was done in, let's say, the last five years. That's my general sense.

Q. Thank you. Thank you. Now, it appears from your report, after having reviewed the two submitted by the parties, you also testify that you agree with a lot of what the State is doing or has done, and the ICORT system is something new that was not discussed at trial. Obviously, this case has not been static. The Court made its findings two years ago, and the State has done some things in the interim which, of course, was not part of the record, and that's one thing that DOJ points out. But if the Court were to go along with that and do what you say do, that is, have a monitor to see how things progress down the road, could -- if the Court accepts the appendages to the PACT units, that's what I'm calling them, and placed that

in the hands of the monitor to see if they are working as proposed by the State, and if it's not working, the monitor could advise the Court, could advise the parties, is that something that a monitor might be equipped to do?

A. Thank you, Your Honor. I think the short answer is yes. I think a first question comes back to what Mr. Shelson raised before, and that is to know what are the criteria. As I've said, I've suggested that the State should offer those criteria, it should offer those criteria with consultation, honest consultation with the federal government, and it would be certainly preferable if there was some opportunity for comment by interested parties in the state who have -- who may be directly affected by all of this.

So the State should go through a process of defining some of those criteria. For example, one that I would mention would be to have criteria for looking at the successful operating of an ICORT team. There is a -- this would be, in a sense, to define its fidelity to the standards. Now, there's no research for ICORT, but there are common sense standards that the State has put in place and to assess, you know, whether the ICORT team is -- whether the ratio of staff to people being served is sufficient, how frequently people are being served, are they being met where they should be met, at a place that's going to be most beneficial to them. So my recommendation is that the State would define what its criteria would be for that.

The government, the federal government should have the opportunity for review and comment, as should ordinary citizens, and then it should be submitted to the Court. And then the monitor would be charged with not assessing independently the State's performance but serving as some kind of an independent reviewer of the State's own data that it would develop and submit essentially to serve as eyes and ears of the Court so Your Honor doesn't have to go through the fine print of all of that. So in a sense, the monitor is a referee.

I've been thinking about this example, just because there's been -- everybody in the courtroom knows the recent success of the Mississippi State baseball team and winning the College World Series. The College World Series is a contested matter, so you don't go out and play that game without umpires, and the umpires make the call, but the calls are made according to rules. So in my view, the monitor would not be making up the rules but would be checking to determine that what was called a ball was, in fact, a ball and to make that recommendation to Your Honor.

Q. With respect to -- let me -- with respect to a future monitor, how do -- have you thought about how the Court should go about having that -- appointing that monitor, who that monitor is, what criteria ought to be used?

We have done them in different instances in different ways. Sometimes the parties could recommend a person or two,

and the persons who they recommend, for example, could come together and recommend an individual. The parties can recommend two or three individuals, and the Court could ferret out on its own which -- who that monitor is, what the role of that monitor will be, and one of the things that I believe Mr. Shelson mentioned earlier, the cost associated with the monitor, because, you know, all of those are to be -- all of those ought to be considered, I think. But how -- what's your experience with the appointments of, and if you have any sort of recommendations about how the Court ought to arrive at that particular person or persons? It may be a monitor team. I don't know. How would you suggest, if you've thought about that, Dr. Hogan?

A. Thank you, Your Honor. Not as much as you have, I think. I think that a relatively simple process where the parties confer, with the ideal of having the parties agree, and if not, a recommendation of their preferred candidates to the Court. I don't believe that this is a matter that is so esoteric that that additional step of agreeing on experts who can then recommend an expert is really needed. I think the -- and the parties would know what they would be looking for. So I think that would work.

I must confess, I haven't thought through and don't really have a recommendation about the budget. As I recommend for the Court's consideration the role of the monitor, I'm envisioning

a lean operation. I mean, I know some people that do this work who have, you know, staff who will go out and inspect things and so on. I'm not sure that this could be done as a solo enterprise, but it's not going to require a staff of six or eight either in my opinion.

One of the reasons for that is that as I've seen this role, as I've recommended this role for the Court's consideration, a lot of the onus would be on the State to be analyzing the data it says it will collect and produce in their reports. It says it will report. And then a few other things that I've recommended, like, you know, how our fidelity reviews are going to be conducted for ICORT or what would be the fidelity reviews that are conducted for vocational rehabilitation services, what is the data that the State would look at regarding the relative amounts of state hospital utilization that are attributable to the different regions, and are those aligned with each other in some reasonable way, or are there outliers where some encouragement or other action by the State might be needed.

So there's definitely more work for the State in this, but in my view, that's work the State ought to be doing anyway to run a good mental health program, and it should have the resources -- the departments should have the resources they need to do that.

So maybe with respect to the scope of the matter, asking

for proposals from the parties would be -- would be adequate. And would there need to be a hearing on that? Could the parties come to an agreement on that? Probably not. Could the parties submit proposals for the staffing and the cost of the monitor's operation that would be at least in the same ballpark? I think probably yes. And then probably the Court might have to -- might have to decide. I think that could be workable, Your Honor.

Q. Okay. Now, in performing the duties that you were instructed to do by the Court, I know when you were appointed, it was our hope, everyone's hope, I think, that you would have the opportunity to come here, to come to the ground, to visit places, talk to individuals and do things on a personal, you know, sort of face-to-face basis. Obviously, COVID had different plans for all of us, and that did not happen.

To the extent that that did not happen, has it substantially affected the analysis and whatever you -- has it substantially affected in a negative way, I guess, the recommendations that you've made to the Court?

A. Thank you, Your Honor. I guess my response is no and yes. No in that -- although it would have been very useful to have more information, to have met with the leadership staff in the department to see how they do their relevant work, to have seen at least a few of the state hospitals and a few of the mental health centers and to have a -- to have a sense of what that

looks like, as Your Honor says, on the ground would have been very helpful, but I'm not sure that in this case, given where the parties have ended up, I can't -- I don't think that would probably have affected what I might have recommended to the Court that much.

The most troubling issue, in a way, has been the -- for me, has been the lack of data or certainty about the system's performance that is ultimately what the Court needs to be assured of. So I think going forward, a monitor would have to spend a little bit of time getting comfortable with that and would have to be available for, you know, concerns raised by people in the state, not that this would be an ombud's role. It is a third party removed kind of role. I would feel better if I had had the opportunity to have more information, but I don't think, Your Honor, it would substantially have changed what I recommended.

As I said in my remarks and as I said in my report, most of what I've recommended is either -- is drawn from the recommendations of the parties, and whether it's to pick one recommendation or to synthesize the recommendation, there is very little that is outside of those recommendations.

The one thing that I didn't comment on when I was speaking before that was not explicitly included in either party's recommendation was this idea of conducting a clinical review. And so I recommend that the order -- the ultimate order that

Your Honor issues would incorporate recommendations for a clinical review.

What I mean by this is that there would be a sample of people who have received core services, or not core services but been in state hospitals or not, who are selected, and then if they're willing to be interviewed as to their experiences, their -- the data on their use of services be examined, and that, in a sense, their experiences with the system becoming the ultimate test of whether things are working. It is good to know the service is funded. It is good to know that after being funded, it is operational and that it's staffed, and it's good to know that people are receiving it. It is good to know that the service meets the State's operational standards. It is good to know if it is true to the way this service is recommended to be delivered. And the ultimate test is whether people find it helpful.

And so I did make a recommendation that there be a clinical review. I recommended that the State be charged with -- with consultation with the federal government and with the monitor, if there is one -- that the state be charged with developing the criteria and the processes for this annual review, or clinical review, and then carrying it out, and then somebody or some people in the state be responsible for synthesizing that information into a report for the -- for the State itself, for the Federal Government and for the Special

Master.

So that process of a clinical review wasn't recommended by either of the parties in their approach. It bears some similarity for sure with the process that the federal government conducted with its outside experts who looked at and talked to many of the 154 people. So to some extent, it is based on that, and it's been an approach that is also used in other -- it's been used in other cases. So as I said, it wasn't recommended by either of the parties, but it seemed to me to be the most foolproof way to ultimately validate that what is being intended is actually happening.

So anyway, I don't think I would have changed things much if I had had the opportunity to interact more with people here.

Q. I've got just a couple more questions. It seems like DOJ, as I recall, talked about 10, 5 and 2. I guess it's the investigation started ten years ago, the lawsuit was filed five years ago, and the Court had the hearing and entered its order two years ago, and we haven't gotten to a final conclusion yet.

How important is it, Dr. Hogan, for us to get final resolution either from this Court or sometime down the road from some other Court, how important is it to get something in place that the Court has found does not exist at least at the time of the record from two years ago? How important is it, in your view?

A. Thank you, Your Honor. I think that is a really good

question. My opinion, my nonlegal layman's opinion about this is that it is very important. This is a matter that has been raised to the Court's attention. The Court conducted a lengthy trial and made determinations about problems that existed. There is no doubt that a lot of progress has been made since the time of trial, but we don't know precisely what it has been. The State asserts that things are good enough or ought to be good enough now, and they may be better than we know, but we don't know.

So it seems to me that some process of validating that the conditions found at trial have been remediated is, I would say, necessary to resolve the matter in an honorable way.

I mean, you know, forgive me, but I'm thinking of another baseball sort of metaphor, which is the story about an old umpire, and I can't remember the guy's name, who is asked, you know, something like, "What's the definition of a ball or a strike." And he says, "It's not a ball or a strike until I call it." And so I think to some extent, that's relevant here. The matter has been raised in the court, and the Court ultimately has to make a determination.

At the same time, there are costs to the State. It costs the federal government too, but there are a lot of costs to the State in carrying this out. And there ought to be, in my view, the most streamlined process going forward of being able to validate that the conditions found at trial have been

remediated.

My personal opinion about that is it's most useful if the State is doing the reporting of those conditions. But also going back to the College World Series analogy, I think it would be somewhat useful to have an umpire to say, yes, that was fair or foul. So I think it should be streamlined. It should be as expedited as feasible. It should include the smallest number of moving parts, in addition to what the State is or ought to be doing anyway. And it ought to have the opportunity for the U.S. government to review it, because it brought the case to begin with. And then ultimately, the Court should decide that the conditions are remediated sufficiently for the case to be terminated.

Q. And finally, with respect to the appointment of a monitor, how long do you recommend that the monitor be in place to find that there -- to determine whether there is compliance with whatever order the Court imposes? And during that time period, whatever time period that it is, would it be the monitor who would set sort of a review process? If it's a year, if it is 6 months into that year, 9 months into that year, 3 months into that year, or if it's a two-year process, should I allow the monitor to sort of gauge when there might be an opportunity to give reporting requirements or something like that?

A. That's a good question, Your Honor. And you sort of go beyond my direct knowledge and experience there, but if I were

to free associate about that, it seems to me that an order might provide for an initial term of two or possibly three years. I would hope that this matter could be resolved within three years, but I don't know that. None of us can know that. I think that the appointment of the monitor -- so in a sense, that would be a term. If the matter was concluded successfully before that, obviously, the term would end. If it wasn't concluded yet, there might be a -- an appointment or reappointment process. It would be streamlined but somewhat like the original one to ensure there is some kind of continuity in that role.

Does that answer Your Honor's question?

Q. Yes. Because one of the things that states do is that administrations change, priorities change, direction of funds change, and so the states are found to have a knack in saying, well, we don't want to commit outside of a particular administration or don't want to commit to doing anything that is going to determine what the legislature says, what the governor says.

You mentioned one point of contention I think that the Court brought out in its order, or at least the testimony revealed that there is money being left on the table with respect to -- and that's the Medicaid money, but that's one thing that the State has ultimately decided, that they would rather reject that money than infuse it into this system. So I

would be concerned about how long the State would be given to bring in everything into compliance and what that compliance actually looks like. That is what we are dealing with.

A. Thank you, Your Honor. Of course, my assessment is that the State has done most of what it needs to do with respect to putting new services in place already. And there are a couple of areas that are outstanding and are more or less contentious, but there's not a lot that is there.

So beyond that, there's the -- it's really the question of the proof that's in that pudding and are things happening the way they are intended to be. So I don't think this ought to be interminable.

THE COURT: Thank you, Dr. Hogan, I commend you for your work on this to the Court and working with the parties on getting through this matter, at least until the point where we are right now. I certainly appreciate your efforts, and I'm deeply grateful for your services.

Now I turn to the United States to the extent the United States wishes to pose any questions to Dr. Hogan. I assume that's Mr. Holkins.

MR. HOLKINS: Thank you, Your Honor.

EXAMINATION

BY MR. HOLKINS:

Q. Good morning, Dr. Hogan.

A. Good morning.

Q. I would like to start with ICSS, Intensive Community Support Services. I believe you testified earlier this morning that the State might need to modify ICSS if performance is not up to standards. Do you recall that testimony?

A. Generally, I would agree with that.

Q. And performance in this context would include specifically tracking and assessing the effectiveness of ICSS in preventing unnecessary hospitalizations, correct?

A. It could include that, yes.

Q. And would that same assessment be necessary with respect to the State's proposed ICORT service?

A. Generally, yes.

Q. Dr. Hogan, I would like to ask you some questions about your report, which is docketed as ECF Number 269. Do you have a copy of it in front of you?

A. I do.

MR. HOLKINS: Does the Court have a copy of the Special Master's report?

THE COURT: Yes, sir. 269?

MR. HOLKINS: 269.

THE COURT: Yes, sir.

BY MR. HOLKINS:

Q. Dr. Hogan, please turn to page 2 of your report. In paragraph 10, you write that "According to the State's report, DMH annual reports, and other public documents, the State has

implemented additional community services since the trial. To be clear, this opinion, Dr. Hogan, is based exclusively on publicly available documents, like DMH's annual reports, correct?

A. Yes, those documents that I cite. I mean, those are the ones that I have knowledge of. And also, we have the State's report in this matter and the affidavit of the director.

Q. Great. And that report and affidavit are all in the public docket, correct?

A. Yes.

Q. Dr. Hogan, you did not review any underlying data, for example, Medicaid claims data, that would substantiate the State's public assertions about these additional community services, correct?

A. Correct.

Q. Is it fair to say that beyond the State's own representations, you have no knowledge regarding whether these additional services are actually operational and functional?

A. Correct.

Q. Indeed, if we turn to page 3 of your report, in paragraph 16, you acknowledge that much of the evidence of this purported improvement has not been validated; is that correct?

A. Correct.

Q. You also acknowledge in your report that based on the evidence at trial, the State's public claims about the

availability of community services did not match the reality for individuals trying to access those services? Is that correct?

A. I think that was demonstrated at trial, yes.

Q. Even accepting as true the State's public assertions concerning progress made since the trial, you recommended that the Court order a remedy to address the State's ADA violations, correct?

A. Correct.

Q. Please turn to page 4 of your report. I would like to direct you to paragraph 17A, where you write, in part, "There is a crucial gap between the funded theoretical capacity of services and the number of people who receive care. Addressing this gap and validating the adequacy of services, not just on paper, is essential to resolving this case." What led you to conclude that validation of the adequacy of services is essential to resolving this case?

A. Well, I addressed that somewhat in my response to Judge Reeves. It may be that everything the State has asserted is true. It just hasn't been tried. It's as if, to go back to my baseball metaphor that everybody is going to be sick of, the pitch has been thrown, but it hasn't been called.

And so since the case is about the adequacy of services, and since gaps and services were documented at trial, it seems to me to be necessary to somehow validate that those gaps have

been adequately resolved.

Q. Just to be clear, turning to 17B, paragraph 17B on page 4 of your report, you note that the trial record demonstrated insufficient management and oversight of the mental health system by the State. Is that correct?

A. That's not exactly what I said, but it's substantially correct, yes.

Q. And does that finding -- did that factor into your assessment that validation of the adequacy of services was necessary?

A. It does, as did some of the other sentences that exist here. And I'm not -- and I say this in part to demonstrate the very real complexity of the matter, not to suggest deficiencies necessarily in the State's response, but this -- I talked about this to some extent before. This community mental health business is complicated. It's not like running a franchise operation. People are variable. Budgets are never quite enough. Staff are difficult to recruit. Local support is variable. Sometimes key people on your management team leave, and all of those things can affect performance. Yet it does seem to me that in this case, performance of that system has got to be ultimately found by the Court to have reached a reasonable and responsive level. And that's why I went here.

Q. Thank you, Dr. Hogan. Please turn to page 6 of your report. In paragraph 20F, you recommend that the Court order

data review that will validate the proposed services are in place, serving people as intended and working as intended, correct?

A. Yes.

Q. Based on the information presently available to you, are you able to validate that the core services the State claims to provide are actually in place?

A. I am not. I defer considerably to the sworn testimony of the director. I think that it's credible testimony, but it hasn't been -- it hasn't been independently validated yet, which seems to me is a reasonable test.

Q. And the testimony you are referencing is the affidavit submitted by the executive director of the Department of Mental Health, correct?

A. Yes.

Q. And based on the information presently available to you, are you likewise not able to validate that the State's core services are serving people as intended?

A. I cannot, no.

Q. And based on the information presently available to you, are you also not able to validate that the State's core services are working as intended?

A. I cannot.

Q. Validating each of these things will require, in your view, additional data, collection and review, as well as

independent monitoring; is that correct?

A. Yes, and precisely what I propose is that the State suggest, with consultation, a criteria for this data, and then the State would report on that data, and if a monitor is ordered, the monitor would review that report.

Q. When you testified earlier this morning that you haven't seen overall performance, and that performance is uncertain, were you referencing the inability to validate that the core services are, in fact, operational and functional in preventing unnecessary hospitalizations as intended?

A. Well, that would be one of the -- that would be one of the key components, yes, but there might be others. For example, it does seem to me, and I suggest in my report, that the department look at, sort of monitor the overall performance of a mental health center. Maybe it does now. I just haven't seen it. For example, are there discrepancies in patterns of the number of people admitted to state hospitals, the frequency of admissions, the number of people who might be admitted to a state hospital without having had the opportunity for a crisis residential service. And there might be variability in people who stay in a state hospital for long periods of time. And those are all useful indicators, none of them are proof, to complement data on service performance.

Q. Please turn to page 15 of your report. I would like to direct you to paragraph 34A. You write here that "The trial

record establishes the need for Court review of progress and that the State's internal monitoring -- although it should provide the great majority of data needed to assess progress -- requires independent validation." See that statement?

A. Yes, I agree with that.

Q. You did not recommend that the State simply be allowed to validate its own progress in complying with the ADA, correct?

A. Well, it seems to me that the State will need to do that once this case is over and resolved, and it should do that on an ongoing basis. But my point is that validation is the route out of the case and into a normal situation where the State is doing that in an ongoing fashion, but not subject to any additional review other than the review of the citizens, the review of the legislature, the review of the auditor, the review of the newspapers, et cetera, et cetera. et cetera.

Q. Just to be clear, though, at this juncture, you're not recommending that the State alone have authority and responsibility for validating its own progress and compliance with the ADA?

A. I do not.

Q. And why did you not make that recommendation?

A. Well, because of everything that we've discussed here this morning. Again, it's as if the pitch has been thrown, but it hasn't been called. It needs to be called.

Q. Let's turn back to page 4 of your report. I would like to

direct you to paragraph 17D, where you write "Monitoring of whether services are in place, available and used by people with serious mental illness, and functioning according to their intent is essential. In fact, monitoring is the pathway to demonstrating that the State is meeting the requirements of the ADA and has resolved the inadequacies found in the Court's opinion and order." Do you see that?

A. Yes, that's my opinion.

Q. And by monitor, just to be clear, you mean independent court-appointed expert, correct?

A. That's my opinion.

Q. Based on your experience as a mental health administrator and your knowledge of the trial record, why did you conclude that monitoring is the pathway to demonstrating that the State is meeting the requirements of the ADA?

A. Because the record can't demonstrate that it's yet being met.

Q. And why, specifically, is a monitor necessary and appropriate based on the trial record?

A. Well, I come back to the baseball analogy. Given the record, which I conclude indicates that these responsibilities are not being met, it seems to me that validation of the performance of the system, which is, of course -- validating that performance is ultimately -- monitoring that performance, measuring that performance is ultimately the responsibility of

the State, but in this case, given that things have gotten to this stage, I think it is contested and an independent approval ultimately by the Court is needed to move back to a more normal situation.

Q. So to use your analogy, would it be fair to say that the monitor at this juncture would be the umpire calling the ball and the strike?

A. Yes.

Q. And that's as opposed to having the batter call his own balls and strikes?

A. Well, you do that in pickup, but you don't do that in the World Series.

Q. At paragraph 17C on that same page, page 4, you write that "The State's new coordinator of mental health accessibility role is insufficient to address the need for monitoring of the State's compliance," correct?

A. As I said, it's welcome but insufficient. It seems to me that given that that emerged from the legislature, it seems to me that it signaled the legislature's concern with this and the legislature's taking an additional step beyond what is normal to do that, which I think is admirable by the legislature, but the legislature is not the Court.

Q. Even if it is helpful, why is it insufficient?

A. For the reasons that I enumerated, this is a complex matter, and it's ultimately up to the art and the craft and the

skills of people in the system to do it. But again, given the status of the case, their ability to do that should be validated before it ends.

Q. Please turn to pages 6 and 7 of your report where you discuss supported employment services. First off, just for the record, IPS stands for Individual Placement and Support, correct?

A. Yes.

Q. And that's the supported employment model that was discussed at length at the June 2019 trial in this matter?

A. Yes.

Q. Would it be fair to say that IPS supported employment is a community-based alternative to vocational services that may be offered in the state hospital setting?

A. No.

Q. Would you clarify?

A. I'm channeling in my mind a comment from Dr. Lynne Stein that I mentioned before, who asked about rehabilitation in the state hospital, said it was like teaching people to skate without having a rolling rink. You can only get a job in the community. So rehabilitation is an essential part of care in a state hospital, but it cannot provide, unless you are living in the hospital and you're going out to work, and some people might, under certain circumstances, do that, if they are a forensic patient who can't leave the hospital, for example, but

you can't really work unless you are living in the community. So there is no equivalency. They are both important.

Q. Just to be clear, vocational services are at times offered in state hospital settings, correct?

A. Yes, I would say they are. I would say "vocational services," they might be labeled that. They might, and they might assist in some fashion, but you can't get a job if you don't have a job to go to.

Q. I think of using the term "vocational" very broadly here, to include things like a sheltered workshop. That would be available in the hospital setting, correct?

A. Yes, it may be. I don't know. Generally, to go on that -- generally speaking, lengths of stays in state hospital have gotten very short for most people who are admitted, and if you are in the hospital for two weeks, which might not be an unexpected length of stay for somebody just admitted, that's probably not enough time to really focus on employment kind of issues. You want to get somebody stable enough to go out into the community. So the one isn't the substitute for the other.

Q. In paragraph 21A, which is on page 7 of your report, you write that "Using IPS versus other forms of employment services is not just a choice between different flavors of a service. The results are substantially different." In this context, the other flavors of supported employment services you reference would include vocational rehabilitation, correct?

A. Yes, unless the vocational rehabilitation services adopt the principles of IPS, which in some cases they do. In some states with some arrangements like Mississippi's, the vocational rehabilitation staff assigned to mental health cases work at the mental health center and function as an IPS specialist, but I don't believe that is precisely the approach that's been used here. The vanilla or usual approach to vocational rehabilitation services is different from IPS in substantial respects.

Q. So let's talk briefly just about the ways that the standard or vanilla vocational rehabilitation service is different from IPS, because you -- we've talked about this before, but just for the record, could you make clear what are the key distinctions between IPS supported employment --

COURT REPORTER: I'm sorry.

THE COURT: Wait. You trailed off, Mr. Holkins.

MR. HOLKINS: I apologize.

BY MR. HOLKINS:

Q. I'll repeat the question. Just for the record, could you clarify the key distinctions between IPS supported employment and vocational rehabilitation?

A. I can, although this may not apply in Mississippi, because I know the approach here, the VR collaboration was developed after the State had already had some experience with IPS. So I don't know the extent to which the VR approach has been

adapted.

Usual VR services, I guess the best way that I can describe it is, they emerge from a model of rehabilitation that historically was kind of like somebody who was working, and then, you know, lost a leg or lost an arm. And the approach is to figure out how to work around that disability by training them to do other things and then placing them in a job. So there's a big emphasis on assessing exactly how people are doing and training them to do something else and then finding a job that is suited for them.

And vocational rehabilitation programs have moved substantially beyond this in many states, and so this may be a dated response, but the last data that I saw on this, which was some years ago, was that the largest category of disability for which people are referred to vocational rehabilitation is mental illness, but that employment outcomes for people with mental illness are worse than most other categories of individuals served by vocational rehabilitation, which in a sense makes sense because it's an approach that isn't really suited for people with mental illness.

And the IPS approach, as an alternative, sees that anybody could potentially work, but the biggest determinant is finding a job and then their interest in that job. So after a very short period of assessment, which largely focuses on their interests and their experience, you go out and try to find a

job.

And then another difference from traditional vocational rehabilitation in many cases, after assessment, training and placement, the case is essentially closed. But people with mental health problems may have issues that emerge. They may have interpersonal challenges with a supervisor, for example. And so a different aspect of IPS is to move into the background but to stay connected if people need a little more support. So those are the main differences. And I say that, again, without knowing precisely how the VR alternative is being implemented in Mississippi.

Q. Thank you. I want to highlight some of the main ingredients of IPS that you've recommended be included in any vocational rehabilitation substitute. The first is availability of the service to all adults with SMI, correct?

A. Yes.

Q. The second is rapid job search and placement, correct?

A. Yes.

Q. The third, integration of the services into the individual's treatment team?

A. Yes.

Q. And the fourth, ongoing rather than time-limited support, correct?

A. Correct.

Q. And do you know whether, at this moment, based on the

information you have available, the State's vocational rehabilitation service contains those key ingredients?

A. I don't know. The only thing that I think I know is that under this partnership, the staff member is dedicated to mental health, but I don't -- you know, I don't know the details.

Q. In fact, you wrote in your report that there is no evidence either in the trial record or the literature to support the effectiveness of the State's alternative supported employment service, correct?

A. That's right. In part, I tried this myself in Ohio, and it didn't work very well, so I've got bumps and bruises on me. But in doing that, I defer entirely to the VR agency on how it ought to be done. That didn't turn out to work so well.

Q. Let's turn to your discussion of mobile crisis services, which is on pages 7 and 8 of your report. In paragraph 22B, on page 8, you reference the State's operational standards relating to the timeliness of mobile crisis services, correct?

A. Yes.

Q. And those standards require that mobile crisis teams respond to the site of a crisis within one hour for urban areas and two hours for rural areas, correct?

A. That is correct. I don't recall whether that is supposed to be achieved for every call-out or whether it is supposed to be an average or something like that. But yes, that is in the standards. And this is -- these standards, by the way, are

emerging -- I would say this is an emergent area. It is not well established. But it is emerging nationally as somewhere between an expected and a best practice.

Q. You wrote that timeliness is an essential element of adequate crisis care. Why is that true?

A. It's self-evident. An individual is in distress, and they don't know what is going to happen to them. They may feel -- they may not feel safe. They may be confused. They may be getting lots of different stuff coming at them. And the longer you stay in that situation, the worse it is for your health and for your recovery. So it's not as -- quite as much of a bright line as it is in stroke care, where if you're having a stroke, you need to get a TPA into your blood soon or the results are going to be inevitable. It is not as much of a bright line as that, but it is more like if you are having a heart attack, you need to be assessed quickly and treated timely. It's a core part of the service.

Q. Let's flip back to pages 3 and 4 of your report, and specifically paragraph 17. You write in that paragraph that the trial record amply demonstrates gaps between service levels that were funded versus those that were available to help prevent unnecessary hospitalization, and you cite mobile crisis as an example, correct?

A. Yes.

Q. Specifically, you wrote that even though the State funds

mobile crisis services in every CMHC region and requires the teams respond within one hour in urban areas, many individuals who needed the services didn't receive them at all, correct?

A. That's what the trial record said, yes.

Q. Would you agree, then, based on the trial record that informed these statements that the State does not have sufficient mobile crisis staffing to satisfy the timeliness of its own operational standards?

A. I'm not sure I could reach a conclusion as to the cause of the problem. It's clear that the problem existed at the time of trial. Is it possible that things have changed between now and then? It's possible. I think, in fact, it's likely that they have improved somewhat because you get better with something like this the longer you do it. Is it likely that it's working as intended uniformly across the state? It's not likely, I don't think, but we don't know.

Q. Just to be clear, what basis do you have for believing that things have improved somewhat since the trial?

A. That's a good question, and it's a fair question. You know, it's largely observing the development of crisis services nationally, which is happening very fast right now, with a lot of time and effort and energy and a lot of attention. And I -- my expectation is that people in Mississippi are paying attention to that and focusing on it somewhat. So it's a hunch. It's not a fact-based conclusion.

Q. Please turn to page 9 of your report, where you discuss peer support. In paragraph 24A, you write that "The evidence shows that peers play a key role in engaging people in care, helping them articulate concerns in a way that can help them get resolved in validating their experiences and concerns." Do you see that?

A. Yes.

Q. By engaging people in care, helping them articulate concerns and validating their experiences, do peer support services help people remain in the community and avoid unnecessary hospitalization?

A. Generally they do, although I would note that the importance and the utility of peer support services in my experience is in relation to several other factors, including how comfortable the individual is in asserting their own needs, how well they understand where they are at in the course of illness and recovery, whether it is a crisis situation or not, and what the setting is. It looks a little different if you are in the back of a police car, for example, than if you voluntarily went to a clinic.

And so it's my -- while I think it's useful, as I said elsewhere in the report, the importance of peer support services is it's kind of not for everybody, but it is most important to be present for people who have the most illness, disability, lack of connection, fright, et cetera, et cetera,

urgency.

Q. And for those individuals who you just described, are peer support services effective in preventing unnecessary hospitalizations and helping them remain in the community?

A. Very often, yes.

MR. HOLKINS: Your Honor, may I have a second to confer with my co-counsel?

THE COURT: Yes, you may.

MR. HOLKINS: Those are all the questions we have for now, Your Honor.

THE COURT: All right. Thank you, Mr. Holkins.

MR. SHELSON: May I proceed, Your Honor?

THE COURT: Yes, you may.

EXAMINATION

BY MR. SHELSON:

Q. Good afternoon, Dr. Hogan. Dr. Hogan, you've been working with the parties a little over a year, and you've certainly conducted yourself honorably, so I would like to echo the Court's thank you for your efforts. Unfortunately, this is litigation, and it's something of an adversarial process, so I hope you don't take my comments in any negative way.

A. Thank you. Understood.

Q. With that said, I do have to ask you some questions regarding your report, and I believe you have a copy of your report in front of you, but I'm going to put it up on the

screen as well. Again, for the record, your report is ECF269.

So, first, a housekeeping matter. In paragraph 4 of your report and several other places in your report, you refer to DMH's operational standards; is that correct?

A. Yes.

Q. Are you referring to the current version of DMH's operational standards as opposed to the one that was in effect at the time of trial?

A. That's a good question, Mr. Shelson. And I know in several of these matters, in several of these cases, in looking at the -- and drafting my report, I went to the Web and saw, first of all, that there were new standards. And second, I think wherever possible, I -- and I -- or I made a reference to them, I was working off the new ones, but I can't be certain I did that a hundred percent of the time.

Q. So -- but in your report, so the Court is clear, are you intending to refer to the current operational standards?

A. Yes.

Q. Thank you. Next, Dr. Hogan, I want to ask you about paragraph 17A of your report that Mr. Holkins asked you about several times, and specifically the gap that the Court found between the theoretical capacity of services and the number of people who received the care.

Now, you recognized in your report that there was an evidentiary cutoff date of December 31, 2018; is that correct?

A. Yes.
Q. And so is it your understanding that the gap the Court found was as of or before December 31, 2018?
A. Yes.
Q. And so what we do know as we sit here today is that the gap the Court referenced is based on data that's approximately two and a half years old?
A. Yes.
Q. Dr. Hogan, I would like to next ask you conceptually about capacity versus performance, but I think it is important to have an understanding of this. So capacity of core services, can we understand that that's essentially asking what quantities of core service is sufficient to meet the need or sufficient to comply with the ADA?
A. I would say yes, with several qualifiers, that is, this capacity could be achieved in several ways. It could be achieved through, you know, direct funding from the Department of Mental Health, or it could be achieved through services that are delivered and reimbursed by Medicaid. And those are slightly different ways to get at capacity, because the first is funded, but you don't necessarily know how much of it has been delivered, and the second is it has been delivered and billed for. With those caveats, I would agree with this definition of capacity.
Q. So, for example, if the Court were to conclude that

Mississippi should have ten PACT teams, that's a capacity determination; is that correct?

A. Yes.

Q. And performance, you've talked about performance several times in describing your report. Does performance essentially ask how well the mental health system is performing, primarily in this case, the core services?

A. I would say yes, but it can get quite fine-grained. For example, to go back to the question of capacity, you know, if we just stick, say, with the DMH grant or contract, a certain amount of funding that has been provided, then you could get into, well, have the staff been hired or not? And then you could get into are the services -- where are the services being provided? Can people get to them? And then you might ultimately get to, so how many of the people who need it are getting it? And then there might be the question of is it functioning the way it is supposed to function or not?

So I gave my example before of this fidelity thing from Connecticut, and they were, quote-unquote, doing ACT, but they weren't doing it the way they were supposed to be doing it. So in my view, performance would include, you know, all of the above: Is the service present? Are people getting it? And ultimately, you might look at things like are the results of the mental health system, let's say in a particular community, are the results of the mental health system reflected and

appropriate levels of use of state hospital or other high intensity services? So all of those things could go into performance.

Q. So for lack of a better way to put it, part of what you testified about earlier is the rub about how you measure performance. Is that correct?

A. Yes, sir.

Q. So that's where I want to go next, and I want to start with mobile crisis. Would you please look at paragraph 38D of your report, which is on page 16. And you wrote that "The State will monitor performance of mobile crisis teams, including response times defined in its operational standard 19.3,E,1." And is that the one hour for response time for urban areas and two hours for rural areas?

A. I believe it is, and I believe in this case, because I cited a specific standard, that I went and looked at the current standard. I can't be a hundred percent sure of that, but I believe it is.

Q. I'll be glad to show it to you. And let me represent, I'm looking at the DMH operational standards that are effective September 1, 2020. So turning to that E,1 section you mentioned, does that refresh your recollection?

A. Yes.

Q. Okay. So it says, "Be able to respond within one hour of initial time of contact if in an urban setting, and within two

hours of initial time of contact if in a rural setting." Is that correct?

A. Yes.

Q. All right. Now, this is where I think it gets difficult. So are you saying that the State, to be in compliance with this standard, must meet this standard one hundred percent of the time?

A. Well, I think that would be nice, but I wouldn't say that. I think what I would say is that the State should define what that means for the State and set some benchmarks. You know, achieving it less than X percent of the time isn't sufficient, for example. I couldn't suggest what that precisely ought to be.

Q. Next I want to talk about crisis residential services, which is paragraph 39 of your report, which is also known as crisis stabilization units, or CSUs. To your knowledge, is there a fidelity scale for CSUs?

A. There is not, sadly.

Q. Okay. So obviously, you didn't propose one; is that correct?

A. Correct.

Q. And so what you suggest to the state monitor regarding CSUs is stated in paragraph 39E of your report?

A. Yes.

Q. And in your view, at some point going forward, the State

should establish the criteria for those items?
A. Yes. And the State is -- I know from looking at data, the State is already measuring the first of these, and that evidence shows that very low rate of subsequent state hospitalization for people that have received crisis residential services. I'm not sure that we know, though, the number of people who got into the state hospital without having had the opportunity to get crisis residential services, which seems to me something the State is well positioned to assess that.
Q. Next I want to go to PACT. And now there is a fidelity scale for PACT. Is that correct?
A. Well, I believe there is. There are these that I mentioned here as examples, but I think the State has got its own. I think it is probably derived from these, and I think it is probably fine, but I don't know that for a fact.
Q. Okay. Let's talk about the Dartmouth PACT Fidelity Scale because that's one that you mention specifically in your report. Mr. Holkins asked you whether -- I believe he did -- whether PACT is effective at reducing hospitalizations. Do you recall that?
A. I remember discussing it. I can't remember if he asked me about it.
Q. Right. And this is kind of an aside, but to your recollection, is reducing hospitalizations one of the criteria

in the PACT fidelity scale?
A. I don't know the answer to that, and I would suspect that it's not an element of fidelity. It's rather a goal of the program to avoid those admissions that are judged inappropriate.
Q. Right. The concept of the PACT fidelity scale is that the higher you score on the scale, the better performing your PACT team is, and therefore the outcomes, like reduced hospitalizations, should be better?
A. It is kind of the active ingredients, yes.
Q. This document I'm about to show you, Dr. Hogan, is in the record as exhibit -- Plaintiff's Exhibit 1078, and it's the Department of Health and Human Services "How to use the PACT evidence-based practice kits." Have you seen this document before?
A. Yes.
Q. All right. I would like to ask you some questions about it, Doctor. I can put it on the screen or give you a copy of it. It's 430 pages.
A. Yeah, don't bother.
Q. Okay. This is page 86 of Plaintiff's Exhibit 1078, and I would like to direct your attention to the part I've highlighted. It reads, "If the total number of consumers is too small to justify having a ten-person team, for instance, in some areas, you will not have enough staff to cover all

evening, week and holiday shifts."

Is this consistent with what I believe was your testimony earlier, that some states have made modifications to the original PACT model for rural areas?

A. Yes.

Q. And do some of those modifications, to your knowledge, include fewer staff members on a modified PACT team because, among other reasons, those teams are dealing with less clientele?

A. Yes.

Q. I would like to ask you -- I don't want to spend a lot of time on this, Dr. Hogan, but just so the Court is clear, this is the PACT fidelity score sheet. Is it your understanding that the -- that there's at least two assessors, and then they come to a consensus score?

A. To tell you the truth, I don't know the precise determinant of how it is done. I don't know precisely how Mississippi does it. I think this is from that SAMHSA document, so this is what they recommend.

Q. Okay. But do you know that there are three scales in the fidelity model: H, which is human resources, O, which is organizational boundaries, and S, which is nature of services?

A. I'm not surprised.

Q. Okay. I will represent to you that there are. Here there are -- in the SAMHSA model, there's 11 H factors, there's 7

organizational factors, and there's 10 nature of services factors. I don't want to get bogged down in that other than this is very important to the State.

I will represent to you that -- this is page 268 of the exhibit, Plaintiff's 1078 -- that the maximum score on this fidelity scale is 140. Are you aware of that?

A. No, but I will take your word for it.

Q. Okay. And do you see where it says a score of 113 to 140 is good implementation?

A. Yes.

Q. And that 85 to 112 is fair implementation. And then 84 and below is not ACT?

A. Yes.

Q. So how does this -- how do these fidelity scales in your mind tie up to whether the State is sufficiently delivering PACT services?

A. All right. It's a good question. I mean, I think if I were running a state system these days, I'm not sure I would use the SAMHSA -- whole SAMHSA kit. It's very enthusiastic and very detailed, but maybe most useful also, just as you are getting started, I think I would have a slimmed-down version that took what responsible clinical people thought was the most appropriate stuff and make that into a reduced fidelity scale.

And then, I think -- as a matter of fact, when I was in Ohio, one of the things that we did is we had teams of people

from mental health centers go and visit another mental health center, and they were the fidelity assessor, which had tremendous benefits. It might not have produced the same, you know, pristine scores, but everybody learned a lot from each other. And then I would set some kind of a reasonable threshold for what was good enough for ongoing performance and what required additional attention and put that in place.

And I think the general approach to this might be if there were modest performance problems, the assumption would be that the leadership of that organization would take responsibility and fix it. And if there were serious performance problems, particularly on unimportant elements, that the state might have to turn up the heat a little bit and require some kind of a plan of correction or plan of action or something like that. But I would have, in a sense, that the punishment fit the crime, not get too carried away with the details.

Q. Are you aware that on these fidelity scales, the assessors rate the criteria on a scale of one through five, one being the lowest and five being the highest?

A. That is typical, yes.

Q. To wind this up, I want to relate this scoring on fidelity to something you testified about earlier, which was this, that measured over a year's time, that a particular service, based on its performance, could come out from under the order. Did I get your testimony on that right?

A. I'm not sure I said exactly that. I guess there are several elements of this. I guess if I were the state -- if I were in the state and I was looking at this graph, I would think that, like, Team B didn't look so good, but now, all of a sudden, they look pretty good to me. They had a low point and they were improved. So somebody took some action in August of '00, and they got better.

And this would not be a circumstance where I would say, you know, you would have to call in the squad. The question of compliance I think is a more finely grained question, I guess, and I'm just thinking out loud here. I guess I would want to know vis-a-vis this case, on the issue of, let's say, ACT compliance, that the State had an approach for looking at it, that the standards were reasonable, that there was an approach for making corrections when that was indicated, and all of this was being maintained in an ongoing fashion, and that there were not loads of ACT teams running around out there staying below the red line. I wouldn't -- it would seem to me to be overkill to do it on a team-by-team, case-by-case basis, certainly for the purposes of the Court, although the people in that mental health center should be paying attention on a case-by-case basis. I don't know if that is helpful.

Q. Here's what concerns the State. Are you aware that the State already measures PACT to fidelity?

A. Oh, yes.

Q. So the State is already doing that. So fine. So how does that relate to compliance and termination?

A. Well, in my recommended framework for that, in this implementation plan, the State would say, here's how we are doing this. And they maybe would say, based on this evidence of here is how we are doing it, we think it is good enough right now. Or they might say, we think it is pretty good, and we think we need to go through sort of one more cycle of managing this, and then we are going to represent that it is good enough. I would handle it something like that. And I think the State ought to suggest reasonable criteria for that measurement.

Q. And as to my point, Doctor, in terms of termination, so let's say that Mississippi was ordered to have ten PACT teams, and over a year's time, nine of those ten PACT teams scored a passing grade on the fidelity scale and one did not, what happens? What does that mean for compliance and termination?

A. Right. I think it's a good question. I don't know what the answer ought to be, but I think it ought to be a reasonable answer. So it might be, for example, that the State would say, we think that our procedures are solid, we think that these scores are pretty good, and either we are going to come back in a few months when this other team has gotten out of trouble, or we commit to monitoring it in the following way, and we think it is good enough for now.

This would obviously -- excuse me for going on, but it would obviously depend on what that level of performance was. If it was horrible, that wouldn't be good enough. If it was horrible and sustained, that wouldn't be good enough. If it was sort of almost good enough and everything was working and good oversight was in place, then you might not have to repeat that grade.

Q. Okay. If we could shift gears to supported employment. In paragraph 43 of your report, I believe you identify the Supported Employment Fidelity Review Manual. Is that correct?

A. I'm not sure. I reference the operational standards.

Q. Let me just show you. This is page 18, paragraph 43E, the underlined.

A. Okay. Right.

Q. You see here?

A. Yep.

Q. I just want to ask you a few questions about that manual. It's a thick manual too. Is this what you are referring to?

A. Yes.

Q. This is page 6 of that manual, the highlighted part. "We recommend that at least two raters conduct fidelity reviews to increase reliability of the findings." Did I read that correctly?

A. That's what it says.

Q. So this is the same concept as the PACT fidelity review,

at least two reviewers, and they come to a consensus score?
A. Right.
Q. So as with the PACT -- this is a Supported Employment Fidelity Score Sheet. And with PACT, there's items, in this case staffing, organization, services, that have subcriteria to be evaluated. Is that correct?
A. Yes.
Q. And then -- so going to the score, here is 73 and below is not supported employment, and then there's ranges for fair fidelity, good fidelity and exemplary fidelity; is that correct?
A. Yes.
Q. Is that correct?
A. Yes.
Q. So again, tying this to compliance and termination, if the State, under this fidelity scale, is at fair fidelity or above, is it good enough performance?
A. Well, again, I would recommend that the State put forward what it believes that should be, and that as the State puts that forward, it seems to me that that ought to include here's what our fidelity standard is, here is how we do it, here's the actions we expect are required to be taken if correction is needed, and here's what the results are expressed in terms of fidelity scores. And then, you know, the whole is what ought to be judged there, not any individual -- any individual

approach.
Q. Okay. And so that fidelity scale would equate with the regions where Mississippi delivered supported employment through the IPS model?
A. Right.
Q. Okay. So where Mississippi delivered supported employment through the VR model, then in paragraph 43F of your report, you list out some of the things that Mississippi should endeavor to measure its performance; is that correct?
A. Yes. This is my recommendation.
Q. Okay. And is it correct that in your report for peer support and permanent supported housing, you did not recommend any performance measures?
A. No, I did not.
Q. I just want to clarify one thing about peer support services. Did you see anything at all in the State's report that indicates that the State is making some attempt to defund peer support services?
A. I've seen nothing that would indicate that. In fact, the State has expanded the services in the state hospitals recently. That's the only thing I've seen about funding.
Q. Did you review the DOJ's proposed plan, remedial plan in this case?
A. I did.
Q. Did you see any specific performance measures in the DOJ's

plan?
A. I don't remember that I did.
Q. If I could refer you to paragraph 56 of your report. I'm going to paraphrase it, but it speaks for itself. That paragraph talks about Mississippi analyzing CMHCs by current compliant status of the CMHCs' core service programs with the DMH operational standards, and where they can be measured by fidelity, be measured by fidelity. Is that a fair summary?
A. Yes.
Q. Paragraph 57 describes the clinical review process you discussed earlier?
A. Yes.
Q. And then paragraph 59 is an implementation plan?
A. Yes.
Q. And I truly don't mean to ask this question to sharp shoot, Doctor, but the State's concern is how to -- how do these three paragraphs work together in terms of what standards the State would actually be under in a remedial order?
A. Well, I think the short answer to that is that my recommendation is that the State consider and recommend what those standards ought to be in its implementation plan. And it ought to say that, just with respect to these items of performance and quality, our standards are on the record, our fidelity process is on the record for these services. For these services where it's not on the record, this is what we

propose. Here is how we are managing that. Here are the thresholds we use for suggesting voluntary improvement. Here are the things that we are committed to do if the performance at the local level isn't good enough. And that would essentially be it, for the State to recommend what it thinks the criteria ought to be.

Q. Okay. Let's shift to the implementation plan. I did the best I could to pull the deadlines, so to speak, that are in your report. And so if I did it right, the only one that extends beyond the end of fiscal year '22 is the last increase in permanent supported housing vouchers is to be made in fiscal year '23. Is that consistent with your recollection?

A. I think that is right. I believe that most of these timelines are as the State included in its report.

Q. And what is your understanding of the fiscal year period in Mississippi?

A. I believe it's a July to June fiscal year.

Q. Okay. So July 1st to -- so fiscal year '22 would be July 1st, 2022 to June 30th, 2023?

A. I think that's '23. I don't -- I think that the fiscal year ends with the ending date.

Q. I'm sorry. You are right. So fiscal year '22 is July 1, 2021 to June 30, 2022?

A. Right.

Q. You were right. I was wrong. Here's my point. So given

the time interval for an implementation plan to go final, 180 days after the Court enters an order, we are going to be pretty close to the end of fiscal year 2022; is that correct?

A. Depending on when the Court issues an order. We would be certainly into that year. If everything proceeded timely, hopefully it would be about Christmas, but --

Q. So here's the point. So you are not suggesting that Mississippi do an implementation plan on core services that are already in place?

A. I am not.

Q. Okay. So the focus, I think, because you said earlier, and I'm paraphrasing, and I don't pretend to say this is exactly what you said, but as I got the import of it, as you conceive of an implementation plan, it would focus on Mississippi establishing the criteria and how to score that criteria?

A. I believe that is right. There might be one or two items. For example, if that one crisis center isn't up and running, then like a timeline for that would probably be in the implementation plan. And the provision of medication assistance might be a new thing, and that would be included.

You raise a question that I have not thought through, and that is that the -- how the Court can be assured of and to validate that additional services that were not present at the time of trial but the State has funded and represents are

present, and I haven't particularly thought that -- I haven't thought that through, but it doesn't seem to me to be a particularly troublesome matter because those issues are, by and large, a matter of public record, and what the implementation plan would address would be the data that the State would provide on those services that are funded and in place. So I think that's how that would be validated.

Q. So if the State defines the criteria and the acceptable scores for the core services that can be measured at some point down the road, then is that what the Court is to use to assess termination?

A. In part, I think that Judge Reeves would likely want to have a recommendation from the monitor that this looked, you know, reasonably kosher and a judgment that it evidenced compliance, but that's sort of a long way of saying yes.

Q. So here's one other thing I'm confused about. So if the State defined the criteria and the scores you suggest, what's the need for the clinical review process that you described?

A. Well, I came to that after sort of sweating bullets on this overall question of accountability, and a little bit of accountability reflects on my strange role here and, as the Court pointed out, that I really haven't been on the ground and haven't seen things. So I don't know anything about the situation on the ground, which is what troubles me some.

So having said that, my sense was that a substantial

portion of what would be needed to demonstrate compliance would be achieved through the State's first recommendations, and second, reporting on the performance of the mental health system. Services were in place, they met operational standards, fidelity was being assessed, bad actors were being improved, overall performance of community mental health centers was being measured, the discharge planning was in place, et cetera, et cetera. And in my view, all of those things would be very close to what was sufficient, but the ultimate determinant might very well be -- and it's the hardest test, is talking to people who have received services and, you know, assessing whether they felt those services met their needs. And that's the hardest test of all, but as I said in introducing myself, I've traveled down this road with my sister, who has been a recipient of services during this whole period of time, and I'll tell you this, my view of the system doesn't look like hers, and her view of the system is more true.

And so I would want a little bit of that element of truth added as the final exhibit that would demonstrate that Mississippi was doing what it was supposed to do and had committed to do.

Q. So let's focus on paragraph 57 of your report, which is the clinical review process. It's the last full sentence on the page that reads "Consultation with the DOJ and monitor will

address at least: Sampling, evaluation criteria and instrument, scoring, reviewer training and reporting." Did I read that correctly?

A. Yes.

Q. Would all of those things except sampling be subsumed in the State's definition of the criteria in scoring you testified about earlier?

A. Well, I'm not sure that I'm following you, but the thing that's different about the clinical review process is that it would focus on the experiences of individual people, and you would have to figure out which ones to talk to. So that ought to be some kind of a sampling process. The rest of this stuff, evaluation criteria and so on, the fidelity scores, that tells you how programs are doing. It doesn't tell you what people are experiencing. So this is just a -- in a sense, it's the icing on the cake.

Q. You, yourself, have run state mental health agencies?

A. I did.

Q. So let me ask it this way. If you were the executive director of Mississippi DMH, how would you tell your board that this order terminates?

A. Well, when I had the order from the Court, that's when I would know. But what I would do immediately, if my -- if the Court were to accept my recommendation, would be to have input into the design of the recommended accountability measures that

the State thinks are appropriate and realistic. And then second, to commit to measuring, according to that. And then, third, using that measurement to demonstrate to the Court that the matter has been resolved.

Q. Okay. So how would you -- what would you tell your board -- what must Mississippi do to get the termination?

A. I would probably be saying, we've done a lot. We've got to do a little more. We've got to demonstrate that what we have done is in place. We've got to look at how well it is working. And we've got to assess how it is doing. And after we have done those things, this ought to be over.

Q. If your board asked you whether termination is to be determined by the satisfaction of specifically enumerated objective criteria, what would you say?

A. I never got asked that question. It's all subjective. So I would say to the extent possible, yes.

Q. But that's my point, Doctor, and I don't mean to be flippant, but can you see how the State would be concerned about how much of it is subjective?

A. Well, as I said before, a lot of this is subjective. This is not as rigorous a science as one would hope, for good and for bad. Some people get bad services and have great outcomes. Some people have great services and have bad outcomes.

And so I think -- I'll go to a different experience that I had that was partly a motivator in looking at this clinical

review thing, which is the one part of this that is probably the most, in some sense, subjective. And I already talked about how -- and I recommended here how this ought to be constructed as to be reasonably consistent and valid, and it ought to be done, then, by credible people whose experience is on the record.

When I was in Ohio, the central thing that I had to do there was oversee a dramatic change in that system that is like this one. In this case, it was driven by legislation, not litigation. But in the period I was there, the number of people in the state hospitals went from about 2900 to about 1200, so this was a dramatic change. A number of hospitals were closed.

I would also point out that during this point in time, every state hospital unit that remained was renovated. The quality of care, as measured by deficiencies, was improved by 95 percent, and so we focused on hospitals too. But one of the things that we did was a research project to look at -- and it was a research project. In this case, it wasn't a matter of court accountability, but we had a study committee appointed by the governor that is something like the board here, although it didn't have those powers, but it was publicly overseeing materials, and the research project involved interviewing and other materials, 400 people who were a sample of thousands of people getting care in the system. For those people, we sliced

and diced all the services that they received, the experiences they had, and then we talked to them.

And this one was a stunner, because what we found was there was no relationship between the services that people received and the quality of their experience. But predicted, the quality of their experiences was whether they had been listened to and whether they got what they thought they needed. And so this didn't mean that we got rid of our licensure standards or we got rid of random inspections or we got rid of accreditation. We kept all of those things because they were essential. But it was an object lesson about the importance of getting people's perspectives on how things were going as a complement to the usual and customary things that governments do to try to measure quality. That's a long-winded answer, but...

Q. Thank you. So as I understand it, what you are proposing is Mississippi define the criteria and the scoring, and then the judge determines, the Court determines whether the criteria are satisfied?

A. Yes, based on a recommendation by the State and a reaction by the federal government, and ultimately a recommendation by the monitor, but the Court would decide.

Q. Okay. So let's put those criteria and scoring in one bucket. Is another factor in termination, then, this clinical review process?

A. As I have described it, that clinical review process would be the icing on the cake of the overall measurement and compliance effort. It would not be the whole thing. It would be, in a sense, the ultimate final data point on how things are going.

Q. So how would -- would there be anything to guide the Court that the clinical review process shows satisfactory performance?

A. Well, I think the state ought to recommend what it thinks that ought to look like, and the federal government ought to have a chance to opine on that. And at the end of the day, that is going to be somewhat subjective, and it would not be, in my view, the ultimate thing that the Court is likely to -- the Court is likely, I think, to look at these other more objective measures of performance, but if -- if all of that said everything was hunky-dory, and everybody interviewed said we had a horrible experience, that would cause a reasonable person to think. I think that is unlikely though.

Q. If I could direct your attention, Doctor, to paragraph 61 of your report, the termination provision. I just want to focus on that. The first sentence, "This order shall terminate when the State has attained substantial compliance with every paragraph of this order and maintained that compliance for one year, as determined by this Court."

So let me break that down. When you use the words

"substantial compliance" in paragraph 61, what do you mean?
A. On the one hand, I mean what it says in plain English, but on the other hand, I mean whatever it says in the State's implementation plan that's been developed with the participation of the federal government and ultimately accepted and approved by the Court.
Q. Okay. And so when you say substantial compliance with each paragraph, are you suggesting that the Court attempt to measure performance of every paragraph in the remedial order?
A. Not exactly. I guess the way that I would envision this, and I'm somewhat of a novice in this particular space, is that the State would come forward and say, we think that we are in substantial compliance now on paragraphs, you know, A, B, C, and here is why we think that. And then the federal government could look at that and agree or disagree, and then the monitor would make a recommendation to the Court.

So my assessment is that in relatively short order, you know, possibly shortly after the submission of the implementation plan, the State would come forward with a recommendation that substantial compliance be found for sort of all of those paragraphs in the order where the State believes it has achieved compliance.

Q. But what are you suggesting that the State develop performance criteria and scoring for other than the core services, if anything?

A. Good question. You know, like, for example, what does the State believe is going to be reasonable and acceptable performance on the discharge planning requirements? I believe the State ought to define what it thinks that ought to be, and so the other procedures as well. So the State should put forward what it believes is the best -- the best way to judge compliance.

Q. So you're suggesting that the State develop performance criteria for discharge planning?

A. Yes.

Q. Do you know of any existing fidelity scale for that?

A. You know, I don't know of a fidelity scale for it, but I think it would be pretty simple to look at the procedure and assign, for example, a criteria for that. The different places I've been in, we always had teams that would go out and look at the hospitals in between accreditation visits and do a kind of a mock survey. That might be one approach to do this. So the State could send somebody out and look at the discharge plan of the few people who have been discharged and decide if that was good enough or not. That would be one option.

Q. Are you aware of any threshold of performance that discharge planning must achieve for a state's discharge planning to be in compliance with the ADA?

A. I do not. I think that would be a matter of professional judgment and maybe ultimately would have to be tested by a

Court, but I tend to rely on professional judgment in that regard.

Q. Are you aware of any performance measure or fidelity scale at all that equates directly to compliance with the ADA?

A. Well, the only ultimate test there is what's been found in courts, but I think a reasonable person's review of sort of all of that evidence together would be where I would draw the line.

Q. For example, the PACT fidelity scale, do you agree that the PACT fidelity scale is not designed to equate to compliance with the ADA?

A. I agree with that.

Q. And would you agree with that for any other fidelity scale or performance measure you know of?

A. I would agree, with the caveat that if -- having people sort of unnecessarily be admitted or readmitted or stay in hospitals, the ADA is clearly about that. PACT is a service that has demonstrated to help with that. Further research has demonstrated that compliance, the degree of compliance with those standards is related to the performance of those programs. So logically, one leads to the other. If you had a lot of PACT programs in place but they were of poor performance, then that would break that chain of logic. So in that sense, the compliance is indirectly related to fidelity and other measurements of quality.

Q. But using -- thank you for that answer, Doctor, but going

back, if I could shift gears back to discharge planning. So you're -- well -- so a review of a sampling of discharge plans as opposed to literally reviewing every discharge plan would be acceptable, some approach like that?

A. I believe so, absolutely.

Q. So the next thing I want to talk about is in this first sentence in paragraph 61, where it says, "Maintain that compliance for one year." And then the next sentence I have highlighted in paragraph 61 reads, "The State may seek and, if justified, may achieve compliance and termination of the Court's oversight for individual major sections of the order, e.g., on individual core services or discharge planning." That's what I inartfully asked you about earlier, so let me tie it up to this specifically.

So in the example I gave earlier, if nine out of ten PACT teams scored a passing score on PACT fidelity, is the PACT section of the order satisfied for the nine out of the ten teams that passed, or is it satisfied for none of them because one team didn't pass, in my example?

A. Right. Well, it's the State that is the defendant here, not the individual PACT teams. So, you know, it ought to be whatever is recommended by the State, with the participation of the government and approval of the Court. I keep coming back to that. But I would think that a reasonable approach to termination with respect to PACT -- and maybe it ought to be

PACT and Intensive Community Support Services overall, but let's just stay with PACT -- would be the services have been funded. Data show that the services are being reasonable utilized. I don't know what "reasonable" means. The State ought to recommend what reasonable means. Fidelity and compliance with the State's operational standards have been assessed, and here's what the track record for that is. And if, at the end of the day, the services have all been funded, they are all serving people at a reasonable level, none of them are serving at 25-percent capacity, and performance is pretty good, then I could see that the State would be found in substantial compliance, even if an individual PACT program performance was not good enough, if the State had a sensible approach to resolve that over time. So it would be -- the compliance would be on the State, ultimately, not on individual teams.

Q. Let me shift gears, Doctor, to a monitor. You used the baseball umpire analogy a few times, so that's what I want to ask you about. Mr. Holkins asked you whether a monitor, by analogy, should call balls and strikes, and you said yes; is that correct?

A. Yes.

Q. So do you agree, though, that using this umpire analogy, an umpire has criteria for balls and strikes, and that is the strike zone?

A. Exactly, yes. The State should define, with the input of the parties, what the strike zone looks like. And then ultimately, the Court would say, yes, that is the strike zone. And then that's what the monitor would look at.

Q. Right. So just to be clear, and I think it is clear, but I want to leave no doubt, what you are suggesting, though, is that the State and not the monitor establish the criteria for balls and strikes here?

A. Yes.

Q. Okay.

A. I do think that the monitor might have input in that regard, and the State would be probably wise to consider that, but I think it's the State's job to do that.

Q. And so you envision that the monitor would have clear, specific and objective criteria under which to call balls and strikes as developed by the State?

A. I think those would be pretty clear. The better job the State did, the clearer they would be.

Q. Okay. So obviously, under your proposal, the balls and -- the criteria for balls and strikes wouldn't be something that would be determined by a monitor at a later date?

A. That is absolutely correct.

Q. I just want it to be clear about the quantity of core services Mississippi has deployed in the field at any given time. What are you saying needs to be validated regarding

that?

A. Well, generally what I recommended was what the State, in its report, had represented was in place or would be in place. So let's stick with that, you know, for starters.

So for those services, it would just be confirmation that they are in place. And then there would be other things, you know, with -- separate from capacity, there would be the question of have they been inspected according to the core standards, has fidelity been reported, and ultimately, you know, are patterns of hospitalization in a given community --

COURT REPORTER: I'm sorry. I couldn't understand you.

A. I'm sorry. I think Mr. Shelson asked me particularly about the capacity of these services. So that would just be is it in place and is it funded. And then there would be, separately, are people using it, and then is it being run right, and then, finally, from other data and in part from this clinical review, is it getting the intended outcomes? I may have meandered a bit away from your question, Mr. Shelson, but that is my sense.

BY MR. SHELSON:

Q. I think -- and if I got it wrong, I apologize, but I think you referred earlier in your testimony to a demonstration -- that there should be a demonstration of the services already in place. Did I get that right?

A. I think that's right, yes.
Q. Okay. To demonstrate whether -- I'm not talking about how it's performing, but to demonstrate the quantity of any given service that Mississippi has in place, you don't really need a monitor to do that, do you?
A. No. Well, the question is, what's the -- what's the valid criteria to demonstrate that, given the trial record. And the trial record, it may all be historical, but it demonstrates gaps between what was funded and what was received.

So somehow we need to just close that gap, and it seems to me that would be closed by the current funded capacity and then the people that are currently being served by that. That ought to close that question, it seems to me.

Q. You agree that capacity in funding requirements are susceptible to being assessed by objective criteria?
A. They are. It depends, of course, what the criteria, but something was either funded or not, and it was either used or not.
Q. Right. So you just addressed funding, but capacity -- here's what I mean. Again, if the Court orders ten PACT teams, then it can be objectively determined whether Mississippi does, in fact, have ten PACT teams or not; is that correct?
A. Yes.
Q. And the same thing with any other service. Of course, that is 16 ICORTS. It can be objectively determined whether

Mississippi does or does not have 16 ICORT teams?

A. Yes, it can. And some of that can get tricky. Sometimes in these matters, you can get into, you know, was there a physician on the payroll on March 31st. And it seems to me that is getting a little too fine for this. So was it funded, was it staffed, were people using it, and was it doing what it's supposed to do? Those matters are more objective.

Q. Yes, sir.

MR. SHELSON: Your Honor, may I have just a moment to consult?

THE COURT: Yes, you may.

MR. SHELSON: Thank you for the Court's indulgence. I'm just about done, Your Honor.

BY MR. SHELSON:

Q. Dr. Hogan, in your proposal, would the Special Master -- excuse me -- would the monitor have any authority to go beyond the criteria that were ultimately established?

A. No. Having said that, I can envision a circumstance where it becomes evident -- this is entirely hypothetical -- that the agreed criteria, you know, are in place, but there's an epidemic of a particular problem that's occurring somewhere. And the question would be how is that relevant to the case and how would it be resolved? And it seems to me that reasonable people ought to agree, and probably in that kind of circumstance, the department would already be on top of here is

what the problem is and here is what we are trying to do. But that's entirely hypothetical. And, you know, mostly I agree that there would be no additional authority beyond that in the four corners of the order and the agreement.

Q. Doctor, under your proposal, would the monitor have investigatory powers?

A. This maybe goes a little bit beyond my expertise. So I'm thinking out loud here. This is ultimately subject to the -- to a decision by the Court in this matter.

Let's say that something -- complaints come in over the transom from somebody somewhere who says that this is -- things are not going right, and something needs to be done; that is, this is to the monitor. It seems to me you can't be silent about that, but the first thing that ought to be done is to ask the responsible officials, well, what's up with this? So the responsible officials would look at it, and their approach would probably be credible.

And I guess I could conceive of circumstances where their approach might not be credible, and it might be necessary to, say, talk to the person who has raised this concern and just assess what's their take on the matter. So in my view, the monitor ought to defer to the responsible state officials as often as is practical but should not be limited from a following up on complaints or concerns if there was a sufficient reason to do so.

Q. Under your proposal, would the monitor hold hearings and take evidence?

A. Not formally. I do believe there would be an exchange of views and ideas among the parties, and the monitor should facilitate that. The reports from the State, if the State has developed a good framework for those reports, should be sufficient. The monitor may have to raise questions back with the State: Can you clarify this, can you clarify that? Those -- the answers to those questions, in the vast majority of circumstances, would be sufficient to resolve the issue. It might be necessary, but it should be very rare, for the monitor to independently verify something, but I would view that as an exception to the rule.

Q. So is the bottom line, Doctor, that the monitor's ultimate job is to inform the Court where the State is relative to the performance criteria and scoring the State develops?

A. Yes.

MR. SHELSON: Thank you, Doctor. Doctor, again, on behalf of the State of Mississippi, I thank you for your efforts and being here in the state of Mississippi. I know it has been a long time, but you have helped move the process along, so thank you.

THE WITNESS: Thank you.

MR. SHELSON: Thank you, Your Honor.

THE COURT: Thank you, Mr. Shelson. I did say the

government would have the opportunity to redirect. Do you wish to do so?

MS. FOX: No, thank you, Your Honor.

THE COURT: All right. We've gone on for quite some time without a lunch break for the court reporter and other staff. Let me ask -- we are going to give you an opportunity to do closings. When do the government lawyers need to be at the airport?

MS. FOX: Your Honor, we currently have a 4:20 flight, but we can certainly change that if it's necessary to do so. I will say that for our part, we are happy to answer any questions from the Court. We have a relatively brief response to what has been said that we would like to share, but we don't have much more in the way of any planned remarks.

THE COURT: Okay. All right.

MR. SHELSON: Your Honor, the truth is, I had I think more extensive remarks anticipated than it appears DOJ does. I think because we have covered a lot of ground with Dr. Hogan, I can shorten it, but if I could have roughly 30 minutes, I would ask the Court for that amount of time.

THE COURT: Okay. Okay. We are still going to take a break. I'm going to try to make sure you can keep your time, but I do want to give the State its opportunity, and again, want to give you all the same. So we will take a 20-minute break. And I'm sorry, court reporter -- I'm sorry, Teri, but

we will take a 20-minute break, and then we will start up with the State's closing, and then we will turn to Mr. Shelson, and I will give you about 20, 25 minutes, if that's -- I may even give you to 30 minutes, but we are going to be moving to try to accommodate them in some way.

MR. SHELSON: Yes, sir.

THE COURT: Dr. Hogan, you can step down. Thank you so much, and you can stay around in the courtroom, and we will get an opportunity to talk.

But ladies and gentlemen, we are going to take a 20-minute break. There is a snack room down on the first floor. So, you know, just make sure you are moving in and about the courthouse as our order and rules require. Thank you. We will be back in 20 minutes, which will be about 1:52.

(PAUSE)

THE COURT: How about this compromise? If everything is done, you have heard all that you need from Dr. Hogan, we can resume the closings at any time, and you can take as much time as you wish in the next couple of days, and we can do that by zoom, if you choose. I mean, I will leave it up to you all. You get your 30 minutes, you get your 45 minutes. You can get whatever you want. The public will still have access to it.

MS. FOX: We would be happy to change our flights if we can -- to give everyone the full time that they need and give accommodations to anyone who needs, you know, a longer

break now.

THE COURT: Okay. So in that case, we will continue on today. Change your flight, then.

MS. FOX: We are going to go change those flights now. Hopefully, they will get us in.

THE COURT: They will. You're the government. That never worked for me.

MS. FOX: Yeah, we might be here tomorrow. And do you want to maintain the 20-minute break?

THE COURT: No, no. We can take a longer break. I say longer. We will take a 30-minute break -- 45 minutes. Since you are changing your flight, we will go ahead and take an hour. And then we will -- please report back at 2:30. And I know the public did not hear that. I know they're running down to one. So show back up at 2:30, and we will proceed.

(RECESS TAKEN AT 1:35 P.M. UNTIL 2:50 P.M.).

THE COURT: Ms. Fox, were you able to -- you and your team able to fix your travel arrangements?

MS. FOX: We were able to buy ourselves a bit of time, Your Honor. The last flight that we could get out today is at 5:30, so I think we have probably an hour and a half or so.

THE COURT: Okay. We will do that. Thank you. I was 15 or 20 minutes late thinking that your flight might have been later, and I apologize.

All right. I'm ready to hear from the United States. We have two governments here. I'm ready to hear from the United States, and I may ask you a question or two in the midst of it.

CLOSING ARGUMENT BY THE U.S. GOVERNMENT

MS. FOX: Absolutely. Thank you, Your Honor.

I just have a few points to start out, and then, of course, happy to answer any questions from you. First of all, I wanted to address the issue of the comparable services that we began talking about earlier and that Mr. Shelson and Dr. Hogan also addressed.

And I have a demonstrative, if I may hand up --

THE COURT: You can put it on the Elmo, if you wish.

MS. FOX: Yes. So to clarify the United States' position on the services that were not presented on at trial, what we are asking for is that the Court's order include a provision that indicates that any of these services need to -- that are implemented must be comparable, with comparable outcomes, so that they also are effective at preventing hospitalization.

What we are not asking the Court to do is to cement in place the system as it is at this moment and including, potentially, services that haven't been proven. So we would prefer an order that doesn't say the State shall develop 16 ICORT teams but rather says the State should develop a service that is -- or implement a service that is comparable in

effectiveness to act in these areas. And then at the monitoring phase would be just assessing that front, which would not necessarily require the State to modify the services that it has right now.

The reason that we prefer not to accept as included directly in the order the new services that the State has developed are because -- is because they have significant differences from those services about which we have evidence for the effectiveness.

So as you can see, there are differences in the composition of the team between, for example, a PACT team and an ICORT team. There are differences in the required number of frequency of contacts. And in the case of ICSS, as was discussed earlier, it is not even a team-based service. It's designed as a time-limited service. And the case load expectation for ICSS is double that of PACT. And so for those reasons, while we think it may well be the case that all of these services produce the effect that we are all looking for, which is a reduction in hospitalizations, we believe that it would be premature to issue an order incorporating those services without that requirement of comparability.

THE COURT: With respect to your chart here with the PACT teams, Mississippi PACT teams, each PACT team that's now the eight, even before the ten or more, each one has a therapist on duty or employed as a member of the PACT team, a

psychiatrist, a nurse and all these people here identified?

MS. FOX: I can't speak to what is actually in their employ right now, but according to the standards, each PACT team is required to have all of those members, yes.

THE COURT: Is that a psychiatrist that's employed or contracted by the State Department of Mental Health or --

MS. FOX: The community mental health center, it can be actually a psychiatric nurse practitioner or a psychiatrist, but they are employed by the CMHC that operates that PACT team.

THE COURT: The reason why I asked that question, of course, no case acts or presents itself to me in isolation. I have another case that involves the United States and Hinds County with respect to its detention center, and we have gone into detail about the beds that they need to get people who have been cited with mental illness and whatsoever, but there's also been a problem, as I appreciate it, with them hiring -- finding a psychiatrist who was either willing to work with them or just finding one who would even apply. So that's why I was asking about the psychiatrist in this context, if there are eight psychiatrists out there in the state of Mississippi, or ten, who are dedicated to these units.

MS. FOX: Yes, and that's one of the reasons that the psychiatric nurse practitioners can be so useful on ACT teams to assist and play that role.

THE COURT: But the ICORT team seems to -- you have

there a nurse. Is that a nurse practitioner or is that just a nurse?

MS. FOX: I don't believe it needs to be a psychiatric nurse practitioner, and so in those instances, individuals served by an ICORT team, my understanding, they would receive services separately coordinated through the CMHC by a psychiatrist on staff.

THE COURT: And I know the State is talking about adding more ICORTS or something as opposed to the strict thing of the PACT teams. Is it the United States' position that we don't know how, because there's no data out there, how that would place itself? And if that is the United States' position, as I asked Dr. Hogan, is that something that a monitor can sort of track and find out as its -- while the ICORT is doing whatever it is supposed to be doing, if it's working efficiently and as it should work?

MS. FOX: Yes, Your Honor. We believe that the State has taken some steps already, it appears, based on their testimony, and so we don't think that there's any reason not to see how that goes and have them present that to the monitor, who would then be looking to ensure that the service is, in fact, effective at preventing hospitalizations and is serving the same population as the individuals with the most intensive needs. And if that is the case, then no modifications would be needed.

THE COURT: Thank you, Ms. Fox. I don't want to eat up all of your time, but go ahead.

MS. FOX: Not at all. This is an important point.

The same generally is true, in our view, around the supported employment issue. So again, we would ask that the Court require that the State implement a service that is comparable in its effect to the IPS supported employment that was in place and was the subject of testimony at trial. And so that -- rather than cementing the VR model into the order, that the Court would either use that same kind of language around comparability or would incorporate the key elements that Dr. Hogan identified as the basic ingredients of IPS supported employment as part of the definition of the service in the order so that those would be, again, included and a part of what is being monitored going forward.

As to monitoring, overall, we know that we did not present a full description of what we were thinking around monitoring in our proposal. We expected that there would be a follow-on set of conversations or briefing around that. However, if you would like to issue a ruling incorporating monitoring at this point, I would be happy to address that in brief. And, of course, we think the purpose would be to ensure compliance.

And as the Special Master suggested earlier, that would include looking at are the services funded, are they operational, are they staffed, are people actually receiving

services, not just any people, but are people who are evidenced to be at serious risk of hospitalization getting connected to those services, and then are they actually preventing future hospitalizations.

We also agree that the clinical review that Dr. Hogan proposed, which is similar to something that we had just toward the end of our proposal, would assist the Court and the monitor in that assessment, as well as the State, in providing some useful information about whether the services as provided are actually producing the intended outcome of this case, which is, of course, compliance with the Americans with Disabilities Act.

And the core elements that we would seek, as far as monitoring, would include, of course, access for the monitor to people, to data, and to records to actually be able to, again, validate the State's reporting. We would then seek regular reporting from the monitor on the State's progress and likely status conferences with the Court after those reports to help inform the Court and the public about the movement toward termination, and then, of course, to also help the State identify where the areas of needed improvements remain, and then the ability for the parties and the Court to speak to the monitor ex parte to help identify issues and bridge gaps.

And we agree with the discussion that you had with the Special Master earlier that the selection could be handled like it was for the position of Special Master, where the parties

could seek to agree, if not, submit names to the Court, and then the Court could select someone to serve in that role.

THE COURT: What about cost? What about payment?

MS. FOX: Typically, in matters that our office has with a monitor, the State pays the cost of the monitoring.

Your Honor, I don't have anything further that I wanted to present, but if you have additional questions, I would be glad to answer anything.

THE COURT: One of the things that have been mentioned earlier today and throughout the litigation, and I think the parties have talked about, the baseline level of services. Is it DOJ's position that that's something that this Court will definitely have to decide, what is -- what does or what does not meet the bare minimum of the ADA with respect to either each of these services independently or collectively, or whatever? I mean, is that a call for this Court?

MS. FOX: Well, Your Honor, I did want to clarify the concept of baseline that came up earlier. As you may recall from Melodie Peet's testimony, she actually testified to a two-step process. She testified to ensuring statewide availability of the services as the first step of the baseline and then a process of assessment by the State as the second step to determine whether the initial statewide level of service was actually meeting the needs of individuals who were at serious risk of entry into the state hospital. So what we

believe that we have put forth to the Court is that initial state of the baseline of services. We do think that through the process of monitoring and looking to see whether in fact people with serious mental illness were at risk of state hospitalization or in a state hospital are getting access to services, that the Court will, through that assessment, ultimately determine whether the ADA has been met. That's the real question at the end of the day.

The proposals are the parties' best efforts to get us to that ultimate outcome of people not being unnecessarily hospitalized in the state hospitals. So we think you start with what has been proposed, and then you'll make an assessment, the monitor will make an assessment over time. It is possible that the State would readjust where services are within the community to meet needs better over time.

THE COURT: A couple of other quick questions. What's the minimum amount of time if the Court agrees with the Special Master that a monitor will be necessary? What's the minimum amount of time that DOJ says that this Court should use a monitor?

MS. FOX: Based on the proposal that we've put forth, the services would be completely in place within three years in the United States' proposal. And then there is a requirement in our proposal, which we think is critical that there be a year of sustained compliance once compliance is achieved. So

the minimum number of years that we believe it would take for the State to terminate the order under our proposal would be four years.

THE COURT: And I heard Mr. Shelson ask the monitor here today, Special Master, Dr. Hogan, today about defining the term "substantial compliance." Will it be the Court's duty and obligation to define that term and the concept of what it would be? I think he said, you know, reasonable people can look at it and sort of determine that, but is it -- if this Court enters an order -- I know typically, when there's a consent decree and the parties have agreed, they define what is substantial compliance, I think. But would this Court have to define what might be substantial compliance?

MS. FOX: As I think you were discussing with Dr. Hogan earlier, there are different -- some provisions lend themselves very cleanly to an objective measure, and some provisions may require additional criteria to lay out exactly how they would be measured. And I think the United States agrees generally with Dr. Hogan's concept that the State could put forth criteria that then the United States and the Court would have the opportunity, and the monitor would have an opportunity to look at those criteria, and ultimately, the Court would determine if they were acceptable ways to measure compliance with each provision.

And then, of course, the monitor would primarily be doing

that work of assessing whether the State had met those criteria that had been established and presenting Your Honor with recommendations.

THE COURT: Does the law -- if this Court were to find that it would appoint a monitor, that that is the best way to do it and do it for three years and say that the State has to go one full year having substantially complied with it, but the State never meets that one year of full substantial compliance -- we have seen it in other cases. We have. All right. So the State never meets that threshold or they, for whatever reason, can't get to that one year of substantial compliance, how long, then, should the Court either throw its hands up in exasperation or continue to make sure that they do it for one year of substantial compliance?

MS. FOX: Your Honor, I think that certainly our office has seen cases that went on longer than any of the parties wanted, and what we think is effective where there are challenges is addressing them earlier on and assessing whether there are changes needed to an order to resolve whatever the challenges are that are limiting the parties' ability to reach termination. So it's possible that at some point down the road, the parties will realize that something that was proposed to Your Honor today or that circumstances have changed. In that case, the parties could come back and present some alternatives, but at this time, the United States believes that

it is both appropriate and possible for the State to come into compliance in a reasonable time period.

THE COURT: Okay. Because I'm reminded about how you opened up: It's been ten years ago since this case started. I mean, that's a long time, and it could potentially be another ten years, potentially, if the State gets on this treadmill of doing good for two years in a row or maybe even three years in a row but can't meet that hurdle, or for whatever reason -- not can't meet, maybe refuses to meet that one year of substantial compliance.

MS. FOX: I think if we arrive at that day, Your Honor, then that's a separate conversation around what the, again, the barriers are to reaching that compliance, but it appears that the State is committed to building out the services, and at this point, it just requires an order to hold everyone's feet to the fire at this point.

THE COURT: Okay. And one final question. Again, I know the public has been somewhat active and involved, and there was testimony from some persons in the public. On any future proposal, will there be an opportunity for the public to weigh in on anything?

MS. FOX: In the United States' proposal, there is a requirement for receiving community engagement in implementation planning and on an annual basis as the State is developing their plan for the coming year for implementation.

So the United States certainly believes there should be a role for the community of individuals who are affected by the system to participate in the development of the implementation.

THE COURT: That's important for -- I mean, that's a necessary and important part of DOJ's plan?

MS. FOX: Yes, Your Honor.

THE COURT: Okay. All right. Thank you, Ms. Fox. You will have an opportunity for rebuttal.

The Court is still undertaking all of these procedures because people in Mississippi, and my home county in particular, 23 percent of people there are vaccinated, and people in Mississippi are refusing to get fully vaccinated, and therefore, we have an increase in the rate of Delta variant. And as I heard one doctor say yesterday on the news, it's the Delta variant today. It's going to be another variant tomorrow and then the next day because you never will get herd immunity or anything else. So we will continue to operate in this way in this courtroom, and I will continue to impress upon my colleagues that they do the same in their courtrooms. All right. I just had to get that off my chest. Plus, I'm getting to that age where I will be 65 in a few more years, a long time -- well, not long, but I have to be concerned about that as well, and underlying conditions. Mr. Shelson.

MR. SHELSON: May I proceed, Your Honor.

THE COURT: Yes, you may.

CLOSING ARGUMENT BY THE STATE OF MISSISSIPPI

MR. SHELSON: Thank you.

Your Honor, I just want to start with a housekeeping issue. This is the United States proposal, ECF265-1. The proposed order uses the term "covered individuals," which includes people at serious risk of institutionalization in a state hospital. Our only point there, Your Honor, is that when one is at risk of serious institutionalization is not defined in the proposed order, and that is a flaw, we submit. Your Honor, this list is not as long -- as bad as it looks.

THE COURT: Let me ask you this, Mr. Shelson. The question, how that is defined, does the State have a definition for a covered individual?

MR. SHELSON: Well -- well, Your Honor, I mean -- our point is that if the State adopts that part of the United States' order, then the serious risk of institutionalization needs to be -- we all need to know what we are talking about, and we don't know what we are talking about at this time.

THE COURT: All right. Thank you.

MR. SHELSON: So these are the seven things I'm going to talk about, Your Honor, and I will just jump right into it.

Let me start, Your Honor, if I may, with the Court's opinion and order in this case, which is -- I'm referring to ECF234, pages 59 through 60. The Court found as follows: That discrimination will end only when every Mississippian with SMI

has access to a minimum bundle of community-based services that can stop the cycle of hospitalization.

Your Honor, we highlighted "minimum bundle of community-based services" only to make the point that as we appreciate what the Court said there, that is a capacity standard. It is not a performance standard. As we understand the Court's opinion and order, the Court did not make any findings about any performance measures which may be appropriate to this case.

Your Honor, to turn to Ms. Peet's baseline standard, the Court effectively asked Ms. Fox whether the Court will have to decide baseline. The State's position on that is that the only thing on record, the only thing in the trial record about baseline is Ms. Peet's testimony. And so the Court did not expressly adopt Ms. Peet's baseline standard as the standard, but that's the only thing in the record. And so it's our position that that's the baseline we all have to go by at this point, and the Court should not try to determine a different baseline because, simply, if it did, it wouldn't be supported by the record.

Your Honor, Ms. Fox also pointed out that there were -- that Ms. Peet's testimony on baseline was a two-step process, step one being baseline, and step two being assessing baseline as time goes by to see if enhancements need to be made. Ms. Peet did testify to a two-step process, Your Honor, but our

point is that Ms. Peet said if you're -- I'm paraphrasing here of course -- but Ms. Peet said if you are at baseline, you are good to go, and we think DOJ should be held to that.

And I will get into this a little further along, Your Honor, but when you start talking about readjustments, that gets awfully vague, and there are just no standards in the record to assess that. And we don't think that those kind of assessments should be made on the fly.

Your Honor, an example of that is one I alluded to in my preliminary remarks is the qualification that DOJ had on mobile crisis teams where they said, okay, a mobile crisis team in each region, but increase the number of teams as necessary within two years. Well, there is nothing in DOJ's report about how to determine that.

And that's a core problem throughout this process is, you know, if we're under an order that calls for adjustments over time, and they are not based on objective criteria, I think the Court can understand why that would give the State some serious concern, because we are under an order that we don't know what we have to do to objectively meet. So when DOJ says things like increase the number of teams as necessary within two years down the road, they didn't do the hard work, which is to say, hey, these are the criteria for assessing something like that.

Your Honor, turning to baseline, which is what I alluded to earlier when I said Ms. Peet's baseline is what it is, and

DOJ owns it, that's the record, and that's what -- that's all DOJ put it in on before they rested on the quantity of core services Mississippi needs, and that's capacity.

Your Honor, we submit that an order which allows the baseline to be readjusted as time goes by, especially one like the ones proposed that do not contain any objective criteria for evaluating the reassessment, exceed the appropriate limits of an injunction. So we urge the Court not to adopt the provisions like paragraph 7 of DOJ's plan that are, frankly, a moving target. And when I alluded to, in my preliminary statement, Your Honor, about moving the goal line, this is exactly the kind of thing I was alluding to.

Your Honor, we can short circuit this a lot on whether -- I framed the issue in the preliminary statement about intensive community services, whether PACT is the only way to deliver ICS. On that point, Your Honor, this was a demonstrative at trial. It was PDX32. This was used during Ms. Peet's testimony for Ms. Peet to identify the core key services, and of course, we all know what those are now. But the point about this slide for today is, Ms. Peet listed both PACT and intensive case management. On cross-examination, and this is trial transcript, page 1435, Ms. Peet admitted that this slide should say PACT and/or intensive case management. So that's what I alluded to earlier today, Your Honor, when I said, according to Ms. Peet, intensive community services can be

delivered by PACT, or some combination of PACT and intensive case management, or Ms. Peet said exclusively intensive case management. So PACT is not the only way to effectively deliver those services.

Your Honor, we asked DOJ Robert Drake about these issues, and Your Honor, this -- trial transcript pages 235 through 239. I'm going to try to summarize this, but I think the record will support my characterization. But we asked whether there's been modifications to the original PACT model over time, and the original model is the fidelity model. And he said that that started in Wisconsin many years back that Dr. Hogan testified about. But Dr. Drake testified that the original model has changed many, many times over the years. And you see there, line 25, Your Honor, "Question: Has it also been modified for rural areas?" And Dr. Drake -- this is page 236, Your Honor -- answered, "Yes."

And the highlighted part I want to jump to. We asked him, "How has it been modified?" And he said, "In rural areas, we don't have a hundred patients with serious mental illness, and we don't have teams that are that large either. So we've needed to do a number of things to modify the model. And most of those have to do with serving a smaller number of patients with a smaller number of clinicians."

Your Honor, that is an excellent description of ICORT. You take PACT, you adjust it with a smaller configuration of

people because, two reasons, in rural areas, and this is supported by the record, Your Honor, number one, you don't have the concentration of people justifying, you know, an 8 or 10-person PACT team. The second thing, Your Honor, is that, you know, you can have a county that in a year's time will send maybe four people to a state hospital, and, you know, it doesn't make sense to have a PACT team bigger than the theoretical maximum number of people you could serve in that county to staff that up.

And, you know, part of what Your Honor found, frankly, is that PACT wasn't working everywhere it was deployed in Mississippi. And part of that is because trying to make it work in these rural areas with -- and Your Honor heard some of this today -- with the mental health workforce shortage that is in those areas, which is absolutely established in the record, just doesn't work.

So it is not that the State is anti-PACT. As I mentioned earlier, we have actually expanded the number of PACT teams since trial, but it's simply a recognition that to keep going down the PACT-only road, PACT, PACT, PACT, is not going to work. So we are saying PACT plus ICORT plus ICSS, because then you have intensive community services in every county. Now, you don't have PACT in every county, but you have intensive community services by some mechanism in literally every county in the state. And frankly, Your Honor, the State is proud of

developing and implementing that.

And we agree, we are not standing here saying that ICORT and ICS work perfectly today. I mean, they were implemented in the year of COVID. It is going to take hard work to make them function like they should, and the State is committed to doing that.

THE COURT: I'm sorry. And I thought I kind of heard that from Dr. Hogan. Many times he prefaced many of his recommendations talking about input from the State, giving the State the first opportunity to sort of define what it can and cannot do. I think that's what I heard Dr. Hogan say, basically giving the State the opportunity to have the first opportunity to put something forward that it believes works, and for DOJ to have the opportunity to respond. And the future monitor or the Court could accept your proposal for ICSS or ICORT or whatever else might work in Issaquena County versus Hancock or Harrison County, I mean. Some things probably will work better in some areas that are so rural that could not be made available in those places that can be made here in Jackson, for example. And I think it is kind of set up where Jackson has more than one PACT team maybe in Hinds County.

MR. SHELSON: No, sir, one PACT team, but in DOJ's plan they propose a second PACT team for Hinds County.

THE COURT: Okay.

MR. SHELSON: But to close the loop on Dr. Drake,

just for clarification, we asked him about modifying PACT for rural areas, and he said, "It does need to be modified considerably in rural areas, but it seems to be equally effective in rural areas."

"Question: As modified?"

"Answer: As modified, yes, sir."

So Your Honor, the Court, of course, recalls that the evidentiary cutoff date was December 31, 2018. So we didn't -- the State didn't develop ICORT and ICSS to be deceptive, but we were constrained by talking about developments later than December 31, 2018, but Jake Hutchens, the Court remembers a senior DMH employee -- this is page 1646 of the trial transcript, pages 18 through 23, we asked him about whether Mississippi was exploring options to deliver PACT services by ways other than the fidelity model. And he said, "We got started looking at smaller intensive type teams with fewer staff that we were hoping we could pilot in an area of the state." Your Honor, that pilot was ICORT.

Your Honor may recall that Dr. Mark Lewis with DMH testified at trial. This is page 1701 and 1702 of the transcript. I'm not going to read this whole blurb into the record, but the Court asked Dr. Lewis about PACT, and Dr. Lewis responded to kind of what Your Honor alluded to earlier, that it just doesn't work to try to stand up a PACT team in place at like Byhalia because, among other reasons, work force staffing

with psychiatrists and that in those type of very rural areas.

The part I want to highlight, though, of Dr. Lewis' testimony is starting on line 24, where he says, trying to use PACT in those kind of rural areas, he said this: "It couldn't be achievable in our state, and we would be back in this court arguing why a model that works in another state can't work in Mississippi." Your Honor, we submit Dr. Lewis was exactly correct, and that's what we are saying. You don't -- if it's not working, you don't try to keep doing it just for the sake of doing it one particular way. And we, frankly, think, Your Honor, that trying to make PACT the exclusive delivery mechanism for ICS is trying to fit a square peg in a round hole, and that the State's proposal, PACT Plus, is the way to go for intensive community services.

On the point about comparable -- Ms. Fox's point about comparable outcomes, it's important to be clear about what we are talking about of comparable outcomes. When Ms. Fox talks about comparable outcomes, there's certainly not a comparison that DOJ proposes in its plan. So as far as what DOJ means by a comparable outcome, that's not -- at least that's not clear to this date what exactly they mean.

And what I'm about to say is in no way to disparage these core services, because we all know that they need to be in place, so there's no question about that. But this is D-235, Your Honor. It was admitted into evidence at trial. And this

is a document Dr. Drake put together on the effectiveness, based on the literature, of these core services at reducing hospitalization.

And so, for example, assertive community treatment, Dr. Drake found that it is 41-percent effective. And what he meant by that, Your Honor, is that -- we asked him to explain that. This is 135 of the trial transcript.

"Question: Could you explain what that 41-percent hospital reduction statistic means as a practical matter?"

"Answer: Well, it means if there were 100 at-risk people who would otherwise be hospitalized, 41 of them would not be rehospitalized during the interval if they received ACT."

And Your Honor, again, not disparaging that result in any way, but that means that 59 of the 100 would be rehospitalized. So our only point is that these services, while vitally important, are not fail-safe.

So to close the circle, Your Honor, if we start talking about things like comparable outcomes, we have to define precisely what we mean by that, and DOJ has not done that.

The best point on alternative ways to deliver ICS, Your Honor, is Dr. Beverly Bell-Shambley, expert witness for the United States, the Court may recall, long-time senior employee of the Alabama Department of Mental Health. She testified that when she retired from the Alabama Department of Mental Health in 2016, that Alabama delivered -- Alabama had two full

fidelity PACT teams, and then the rest of what Alabama had at that time was modified PACT teams for rural areas. So I think Dr. Hogan mentioned other states have modified PACT for rural areas to ICORT-like models, and the record shows that Alabama was one of them.

Your Honor, this is from United States' proposal ECF265-1, paragraph 3. I'm not going to read the whole thing, but the long and short of it is that if the State wants to introduce an alternative service, the State has to petition the Court to modify the injunction to replace any core service with a comparable alternative.

First, Your Honor, as I said this morning, ICORT and ICSS, which I think is what we are really talking about in this regard is not -- we are not replacing anything. Again, Your Honor, not to be repetitious, but we have increased the number of PACT teams. We are not asking the Court to allow us to reduce the number of PACT teams and replace the PACT teams we reduced with an alternate service. We are saying expand PACT and then expand the delivery of ICS further through ICORT and ICS.

But, Your Honor, I think that -- while at least Justice Kennedy in his concurrence in *Olmstead* foresaw this type of thing coming up, and Your Honor, this is *Olmstead*, page 612 of that decision, the highlighted part, "Grave constitutional concerns are raised when a Federal Court is given the authority

to review a State's choices in basic matters, such as establishing or declining to establish new programs."

So we would urge the Court not to -- we would urge the Court to reject the kind of pre-authorization concept that DOJ is proposing.

THE COURT: I could go back and look at that myself, but tell me who else joined that opinion. You said it was Justice Kennedy's concurrent opinion.

MR. SHELSON: Yes, sir, I'm not representing that was the majority --

THE COURT: No, no, I'm just asking. Anybody else join it?

MR. SHELSON: I think as I recall that opinion, there was a majority part, and there was a plurality and then there was a concurrence part by Justice Kennedy, and then there was a dissent by Justice Thomas. Now, I don't believe, to answer Your Honor directly, that any other justice expressly joined Justice Kennedy's concurrence.

THE COURT: Okay. I mean -- we will look at it.

MR. SHELSON: Yes, sir. I could be --

THE COURT: No, that's fine.

MR. SHELSON: I could be wrong about that.

Your Honor, if I could skip ahead to this implementation plan. I'm not sure where we -- I'm not sure what is exactly being proposed. You know, those provisions in DOJ's plan and

the Special Master's plan say what they say.

As I appreciate what the Special Master is saying is that his conception of the implementation plan would focus on the State developing the criteria in scoring that performance would be judged by. I think that's certainly different than the literal words on paper that DOJ has proposed. DOJ's proposal, as we read it, is pretty open-ended, and it is not as focused as Dr. Hogan described his concept of an implementation plan.

Your Honor, we are concerned at the remedial phase. You know, Your Honor may hit the pause button, I don't know, but we are concerned about a remedial order being put in place and then essentially figuring out the criteria to judge performance later. We just don't see how that could be consistent with the law, Your Honor.

You know, I mean, fundamentally, and I think -- I mean, fundamentally our position is that whatever performance measures DOJ believes should be in place should have been introduced in an evidentiary manner at trial. Well, they weren't. And, you know, I think I could be wrong, but I think we argued in closing that our position was, you know, DOJ had the burden on the remedy, and it was our view that they didn't satisfy that burden at trial. And now we are two years later, and DOJ has submitted a written remedial plan, and Your Honor, they gig us for no accountability, but they haven't -- I mean, two years after trial, they have had a chance to submit a

remedial plan in writing and there are no performance measures. There's not a single performance measure in their plan.

And they are saying, "Hold the State accountable, hold the State accountable." The State, within reason, is not opposed to accountability. Of course not. I mean, who can argue against accountability? But what we are opposed to is figuring out accountability later. We just don't see how that can be right, Your Honor, under the law.

THE COURT: So what does the State wish? That the Court finds today, for example, that the State has not met its measures and the State comes up with something out of its head that is ill-informed? Because I'm not a mental health expert. I think that's what I've used Dr. Hogan for, to help figure out what programs might be needed, and might I need some guidance down the road with a monitor to help set those goalposts, and then to be informed later on whether or not the State is meeting those goalposts over a period of time.

MR. SHELSON: Our position on that, Your Honor, is the Court should take the record as it is, and the record as it is is there's no performance measures before the Court from DOJ to adopt. So if I could -- Your Honor, just bear with me a second, here.

Your Honor, this is from the brief that DOJ filed in support of its proposed plan. This is ECF266, page 3. And this is -- I'm sorry, Your Honor, but this is actually going to

answer your question.

DOJ wrote, "The State is unwilling to be held accountable to this Court for many of the provisions in its own report recommending that the Court enforce, at most, 13 of the 39 paragraphs in the report."

First, we disagree that we are unwilling to be held accountable. Second, that 13 of the 39 paragraphs part, there's a rationale to that, actually. The 13 paragraphs, and they are correct about that number, the 13 paragraphs that they mention there are the capacity and funding provisions in Mississippi's report. And our point is twofold: First, that everything before the Court, the things that can be objectively measured are capacity and funding. And so, two, taking the record as it is, that is all the Court has before it that are objective criteria.

And so it's the State's position that on the record before the Court, it has two things that can be objectively measured, capacity and funding, and those should be the objective measures for compliance and for termination. So if the State meets its commitments on capacity and funding, then the State is in compliance with the ADA and the order should terminate.

THE COURT: Let me ask you this. We are in the middle of fiscal year 2022, I think -- well, no, no. Not in the middle. We just started it July 1, I guess. If the Court were to rule three or four months later and the State disagrees

and decides to appeal, which it obviously has the right to do, what record -- suppose the State develops more ICORT teams or the related teams other than PACT teams between today and, say, December, but the Court doesn't rule on anything until, you know, November, there's a record -- well, the State decides that it's going to appeal, but as of today, I have what has been done through today, for example, will the State be able to argue, if it appeals, that, see, we are doing the right thing, this is what we've done since the judge's order, or will the Fifth Circuit be bound by the facts as they existed before me at the time that I rule, or after today's argument, for example? Because one of the real things that have been going on here is that the State has had an opportunity to do more, but I closed the record in December of 2018, for example, and -- but obviously, there have been changes, and everybody agrees that some of the change has been good.

So if the State decides to appeal, will they be able to show the things they have done post judgment? Will they be able to show that to the Fifth Circuit?

MR. SHELSON: Our position, Your Honor, is yes, and here is why. The liability record is closed. This is essentially -- essentially, we've split -- we've bifurcated liability and remedy. And so especially given the time between the evidentiary cutoff date and even now, as far as remedy, because we think that under the law, the Court should take into

account the current status because it just, legally and common sense, from a common sense perspective, it doesn't make sense to order things that -- in a remedy that weren't in place on December 31, 2018, but are in place now.

We submit that the Court should not ignore -- ignore may not be the right word, but the Court should consider the changes, and the Court -- certainly the Court did not rule that the Court will consider further changes, but it certainly has alluded to the possibility of further changes. And so I think under the law, they should be taken into account.

And, you know, we would suggest that the Court -- that the State, by making changes since the Court's opinion and order, has certainly shown that it's not being intransigent. I think the Court would be displeased if Mississippi took the position that no issues here, we're not expanding anything. That's not what we've done, and it's certainly our understanding that the Court didn't want Mississippi to stand pat. And the intent of why we are all here is to move the system forward. That's a long way to say that.

For remedy purposes, the changes that Mississippi has made, it is certainly our position that this Court and, if there's an appeal, the Fifth Circuit should take them into account.

THE COURT: Thank you, Mr. Shelson.

MR. SHELSON: So, your Honor, I will just cut right

to it. I think it is structurally wrong and conceptually wrong to put the State under an order and then figure out the criteria by which the State will be judged for compliance and termination.

Again, Your Honor, you know, DOJ is the plaintiff who can argue the burden of proof on right of issues all day, but it's that distinction between capacity and performance that I went over with Dr. Hogan. Everybody knows what the core services are. Everybody knows what the capacity issues are, so that is fine. But performance, Your Honor, those issues just are not in the record. And if I could, Your Honor, I'll be precise about what I'm talking about there.

Performance measures based on the trial record. Your Honor, first, there's nothing in the record regarding what should be measured with any specificity. There's nothing in the record with any specificity regarding what should be measured in the remedial plan. And two, there's nothing in the record correlating any particular performance measure to compliance with the ADA.

That's what I was talking about with Dr. Hogan, Your Honor. So you have your PACT fidelity scale. What score on the PACT fidelity scale is compliance with the ADA? Well, that's not what those scales are designed to do. I think everybody recognizes that.

So on performance measures, there's just not a record on

the performance measures should be A, B and C, and you have to achieve this score on A, B and C to be in compliance and to get out from under the order. And, Your Honor, again, I think it's objectively reasonable why the State would be deeply concerned about those things not being in the record, one; and two, being put under an order that says develop them at a later date. I don't see why we are going under an order in the first place. That's my point. If we are being judged to a performance standard -- bottom line, Your Honor, I will just cut right to it, it should have been put in the record. If the plaintiff wants it, it should have been in the record before now, and it's not. And we frankly think that, therefore, you should go -- you should strictly judge performance based on capacity and funding.

THE COURT: Let me ask you this question in that regard with where we are. You mentioned we've sort of bifurcated this thing so far with liability and remedies. What if the Court were to enter an order, a final order, 54(b), on the liability and allow the parties to do whatever discovery they might need for a brief period of time and get whatever evidence they might need with respect to a remedy, a full remedy that could be proposed? Because right now, I think, we are saying that we don't know what the remedy is, we don't know what the goalposts are, but give the parties an opportunity to develop that aspect of the record while the other side is fully

being appealed and litigated to the Fifth Circuit, if necessary. You know, obviously just because one does 54(b) doesn't mean anyone has to take advantage of it at that point. What would be the State's response to that possibility?

MR. SHELSON: The truth is, Your Honor, I haven't specifically asked the State that question, so I can't give the Court a concrete answer on that. I don't mean to dodge your question. It's a good question, but I, frankly, haven't asked the State that, so I don't know what the State's position is on that.

My impression, Your Honor, is that the case -- to be clear, the case has evolved into bifurcation. But to be further clear, no one has ever moved for bifurcation. There was some point in the proceeding, I don't have the record cite but it is in there somewhere, the Court asked DOJ whether they wanted a bifurcation, and DOJ said no.

So part of our position is that DOJ should have put on their remedy proof before they rested, and they didn't. And we are going to argue that that's a problem for them going forward.

So that approach is less than ideal, I think, from the State's perspective. I mean, I think at this stage, two years after trial, after remedial plans are submitted, that whatever is next needs to be complete relief. And when I say complete relief, I mean not issues left for another day, whether it is

implementation plan or the monitor or the concept of the State devising the criteria in scoring that it's going to be judged by.

It also begs the question, frankly, Your Honor, how many chances at this does DOJ get? We had a month-long trial, they rested, had an opportunity to submit plans. DOJ submitted a plan. And if it's not in there now, Your Honor, our position is that whatever relief they are seeking that's not sufficiently enumerated in their plan, they should be denied that relief.

So two or three quick examples -- two examples -- three: Accountability and performance measures. They didn't submit any performance measures. They don't get another chance down the road to do a back door through the State coming up with an implementation plan. They didn't propose one. I mean, they proposed having one, but they didn't propose -- they didn't identify any of the details. And the monitor, they just said have a monitor, and the duties, compensation and authorities would be dealt with by a separate order. So those three things should be foreclosed as relief to DOJ because they did not sufficiently specify what they are really asking for.

THE COURT: But I know how DOJ works, and from the perspective of DOJ, and also from the perspective of sitting here, they do their investigation first, they give the State notice of their investigation, they ask the State to cooperate

with -- this is any jurisdiction, because I've seen it on the local level too. They tell them, "This is what we have, this is what we see going wrong. How are you going to fix it? Please fix it in this way." And there's usually going back and forth.

And that reminds me of Ms. Fox's thing, ten years ago, because it was five years before they filed suit. And during that five-year period, they were going back and forth with the State, I presume, like they do in most cases, going back and forth with the governmental entities. So I'm not just suggesting that it is just the State. I have seen it in other cases. They go back and forth with them, whether it's the civil rights division, the mental health, the *Olmstead* people here, or some other group that finds systemic problems with how the State might be violating constitutional rights of its citizens. They go back and forth.

So, you know, if DOJ had filed the suit ten years ago, we probably wouldn't be here, but they have worked with the State for five of those years. And then, of course, you then have litigation, which everybody is entitled to respond in a way when they are sued or all that. And now we are here today, still haven't gotten to the end.

So might it be helpful for the parties to think about, since in the State's position, the DOJ still has not defined a goalpost nor set a goalpost or anything, shouldn't we give the

parties an opportunity to figure out what those goalposts are, while at the same time the State of Mississippi objecting to it all by going to the Fifth Circuit on the findings or the liability issues?

MR. SHELSON: No, sir, because the things -- the things you just identified, none of those would be in a position to go up.

THE COURT: Okay.

MR. SHELSON: And it would be related to the issue of, at least Mississippi's position, that DOJ should have done all of that before they rested.

THE COURT: Okay. Thank you, Mr. Shelson.

MR. SHELSON: Your Honor, a monitor, I think we have covered that. Our issue with the monitor is, again, this concept of an order issuing before the monitor's duties are fleshed out, so we just can't see how that could be appropriate injunctive relief.

You know, the Court would effectively be saying, I'm going to order a monitor, and again, I don't mean this flippantly, but we are going to figure out at a later date, after the order enters, what the monitor is going to do. Your Honor, we just don't see how that could be appropriate under the law.

Your Honor, DOJ's termination provision, this is paragraph 55 of their plan, order terminates when the State has attained substantial compliance with paragraphs 1 through 54 and

maintained that compliance for one year as determined by this Court. Your Honor, we have already talked about this, so I won't belabor it, but substantial compliance is a term of art in that provision. It's not defined. We don't know what it is. And that's what I alluded to this morning when I said Mississippi cannot know what it must do to exit from DOJ's termination provision.

THE COURT: But could the Court define substantial compliance as being in compliance with 75 percent of the 54 paragraphs? I mean, could the Court say that that would be substantial? Any of the -- any paragraphs that total 75 percent.

MR. SHELSON: No, Your Honor.

THE COURT: It could not?

MR. SHELSON: Let me be more careful what I say.

THE COURT: The Court can do it. That's what you are about to say, right?

MR. SHELSON: Your Honor can do it, but Your Honor should not do it.

THE COURT: Okay.

MR. SHELSON: Because it is impossible to objectively meet that. And let me just show you what I mean, Your Honor.

You know, we hope that when Your Honor asks the question how do we measure success along the way that Your Honor wasn't suggesting literally measuring every paragraph in order. I

mean, the United States ordered 13 pages single-spaced.

So, again, Your Honor, the point I made earlier about the State is willing to be held accountable about what can be objectively measured, and the only thing, again, in the record that can be objectively measured is capacity and funding. When you get outside of those, Your Honor, bottom line, it is whatever that results in, it's a hundred percent made up post trial, and we think that is just wrong.

And Your Honor, when you get out of capacity and funding, frankly, some of this is important, but it is aspirational. This is paragraph 2 of DOJ's plan: "CMHCs shall be the entity responsible for preventing unnecessary hospitalizations by" -- and then it lists these four things. Just the first one, Your Honor, "Identifying individuals with serious mental illness in need of mental health services," there's nothing in the record, Your Honor, about how one would measure something as open-ended as that. Things like that, Your Honor, just shouldn't be subjected to performance measures.

I mean, it's kind of like an -- how do you do that? Certainly DOJ has given no one any guidance on how you would get to something like that. That is far different than saying "Thou shalt have ten PACT teams." We can do that. "Thou shall spend $200,000 a year on a Medicaid assistance fund." Objectively, you do that or you don't. If we literally have to go through this line by line and come up with a performance

measure for every one of these, first of all, I don't -- there's never going to be an agreement on that, so we are going to be right back here arguing about it.

THE COURT: I mean, couldn't the CMHCs, for example, alert all hospitals, all school districts, all public bodies, courts, or chancery courts, to just make sure that they are -- that they alert the community health system of everyone who they come in contact with who they believe have a serious mental illness?

For example, chancery courts, they get orders all the time, or they get petitions where they are trying to get people in -- try to make sure that those persons who -- I can't think of the word right now, those persons who need to be committed. There's a petition filed in chancery court claiming that this person here cannot take care of his or her business, cannot take care of himself, and needs to be committed based on these affidavits of these particular doctors. That Court has a hearing, that Court determines whether that person ought to be committed. Couldn't there be a relationship with some entity on the fed side with these groups that could help them identify persons with serious mental health issues? Couldn't it be structured in a way where that would help reach that goal objectively?

MR. SHELSON: There could be, Your Honor, but three things: Number one, there is nothing in the record that says

things like that should be measured. Number two, there's nothing in the record equating something like that to compliance with the ADA.

We would ask what's the authority that an issue like that is in any way related to compliance with the ADA, that in other words, if the State doesn't do what Your Honor just said, it's not in compliance with the ADA? We just don't think that's the law.

Now, having sufficient quantity of core services, I'm not going to fight that. There's a radical difference between the two. One you should measure, and one you plainly should not, and that's our point. When you talk about every paragraph in here, first of all, there's nothing in the record establishing the need to measure anything in here besides capacity and funding.

Now, if you sit down and try to devise a performance measure for literally every sentence in here, your performance measures are going to be longer than your order, and this case is going to survive me. It's just not happening, Your Honor.

THE COURT: All right.

MR. SHELSON: And when I said it portends a perpetual order, that's the kind of thing I'm referring to. It's not feasible.

Dr. Hogan, I asked him about that, and he said you can measure things like discharge planning by not literally looking

at every person discharged by doing a sample. But that just illustrates the complexity of trying to come up with performance measures with literally everything in here.

If I could, Your Honor, I know we are short of time, but just one more example. This is paragraph 40 of DOJ's proposed order. This is talking about discharge planning. And it says, "The State, through the CMHCs, shall" -- and then it lists four things. The first thing is actively participate in the discharge planning process. Your Honor, of course the CMHCs should actively participate in the discharge planning process, but how do you measure that? And I don't mean to ask that as just a rhetorical question. I mean, I'm sure someone could come up with something, but, one, why are you doing that? Where does the ADA say you have to measure something like that?

And in terms of being -- is it truly DOJ's position that if we do not devise a measurement for whether CMHCs are sufficiently actively participating in the discharge planning process that the State is violative of the ADA? We don't think the ADA says that. That is going way, way beyond any reasonable requirements of the ADA.

And number four there, this just illustrates how impractical trying to measure everything is. "Implement the discharge plan." Well, of course the discharge plan should be implemented, but Your Honor, a discharge plan could last a year, could last five years, could last 15 or 20 years. So at

what point in time do you make that assessment? And do you take a sample of them, like possibly Dr. Hogan alluded to in a different context? But, Your Honor, it's truly a nightmare to try to come up with measurements for literally everything in here.

So we think that at trial, DOJ should have at least established via admissible evidence, one, what should be measured and, two, how to measure it, and they did neither.

THE COURT: Okay. Thank you, Mr. Shelson. Let me ask DOJ, I know you said a 5:30 flight, and I know -- and I'm not even sure if Mr. Shelson is through. How does DOJ wish to proceed? I mean --

MS. FOX: Your Honor, we are happy to change our flights again, if necessary, and go back tomorrow. This was the last flight that was available for today, but we want to make sure that the State has a chance to fully make their arguments.

MR. SHELSON: We don't want DOJ to miss their flight, Your Honor. We would propose going to concluding this remotely.

THE COURT: And I will allow for that. It is left up to you all. Every time one speaks, I might have another question. That's all I will say, as Mr. Miracle knows.

MS. FOX: We are comfortable continuing and allowing Mr. Shelson to proceed, and we will rebook.

THE COURT: I just have one further request, that you spend as much money in Jackson tonight as you can.

MS. FOX: We have done our best for many years, Your Honor.

THE COURT: And we appreciate it. Okay, Mr. Shelson. I'm not. And that's not in any way taking away from the seriousness of these proceedings. I don't want anybody to go anywhere talking about the judge didn't take -- I'm taking it very seriously. I'm just trying to add some levity to the proceedings.

MR. SHELSON: So, Your Honor, the third defect in DOJ's termination provision is, and again, we mean no disrespect whatsoever to the Court when we say this, but it ultimately leaves termination to the discretion of the Court, and we are not disparaging the Court's equitable discretion.

But here are our points: Number one, DOJ is proposing the exercise of judicial discretion in the absence of any rules or objective criteria for termination. And so what they are suggesting, as we just went through with some examples, is discretion regulated only by whether the Court believes Mississippi is in substantial compliance with 50-plus paragraphs of a remedial order. Number one, we don't know that you would want to take that on. And number two, that the core point is that when you are talking about a termination provision, in this case Mississippi should know by clear,

specific and objective standards what it must do to terminate the order. And DOJ's proposal as it exists now, again, Your Honor, it doesn't contain clear, specific or objective criteria for termination. In fact, it contains none at all. And two, therefore, Mississippi -- Mississippi cannot know what it must do to terminate this order.

We kind of went through it a little bit with Dr. Hogan, but, you know, how would -- we would ask the Court to consider it from this perspective. Of course -- I will just ask the Court to consider it from this perspective is all. What must Mississippi do with any reasonable degree of specificity to terminate this order as it's proposed by DOJ? And we would submit, on careful reflection, that that question cannot be answered.

So it circles back, Your Honor, to what I alluded to. So, again, based on what's in the record now and in these proposed plans now, what can be objectively met, what can be objectively measured?

You know, performance and accountability, again, the things in there now that can be objectively measured are capacity and funding, and it's our position that you don't need a monitor to assess capacity and funding.

Your Honor, our position on the remedial phase is distilled to this: No remedial order or monitor is necessary to assess where Mississippi is relative to its capacity and

funding commitments for the reasons in our response, which is ECF262.

Now, if the Court nonetheless disagrees, there are four considerations we would ask the Court to apply, and I will go through those very briefly, Your Honor, because they are in our brief. But consideration number one, judicial oversight of a state's mental health system is problematic and should be limited in time and qualitative extent to what is absolutely necessary. I'm not going to belabor this, Your Honor, because I think the Court recognizes this point, ECF234, page 59. The Court talked about it being keenly aware of the judiciary's limitations in cases like this, and that's what we are talking about. So when the Court is invited to exercise its discretion in termination where there's -- the party asking the Court to do that has not put in the record any objective criteria to guide the Court in exercising the Court's discretion, those are the problems I think that the Court is keenly aware of.

Consideration number two, this is what I alluded to earlier, Your Honor, any prospective injunctive relief must account for the current state of affairs in Mississippi's mental health system.

The Court, in its opinion order, page 60, noted that the possibility of further changes being made after the factual cutoff. So again, Your Honor, Mississippi certainly didn't interpret the Court's opinion and order as being to maintain

the status quo. The Court found deficiencies. The State is working to correct them. And we have never said that anything -- that everything is running perfectly. That will never happen in a system of scale, but the State has tried to move the system forward. And frankly, that should be, we submit, to the State's credit.

Consideration number three, Your Honor, is the ADA should not be applied in a way that would create serious and ongoing federalism problems. I mean, I think it is clear from the inception of the trial, after DOJ's opening statement, the trial transcript, pages 57 through 58, the Court asked whether the United States was expecting the Court to take over Mississippi's mental health system. DOJ said no.

The problem is, Your Honor, is if you -- I mean, just -- the State looking at this as it exists now, which is a proposed plan from DOJ with no performance measures, with a monitor whose duties and authority is absolutely not specified, and a termination provision that on its face has no objective criteria for termination, they may not mean to be, but Your Honor, make no mistake about it, that the Court is going to be running the state's mental health system either directly or indirectly through a monitor if DOJ's plan is literally adopted as it was presented to the Court.

THE COURT: But if the Court -- again, the Court has found that there was some -- that the State of Mississippi has

violated the ADA. The Court has found that. And so if I do nothing now and it is -- if I do what the State wishes and there's an appeal, or if I do something that one party disagrees with, at the end of the day, the Fifth Circuit could agree that Mississippi was in violation of the ADA. And then they can remand it to the Court for remedies, right?

I mean, "We agree with you, District Court, that Mississippi was in violation, but you've not -- but you have not been afforded the opportunity to or the remedy that you ordered was not the right remedy. Please go back and have the parties litigate the remedies issue." And all the while, Mississippi still may be in violation of the ADA, because it may not be providing the sources that the public needs. It may not be doing what they need to do with respect to X, Y or Z, and that would put us in a position where we are today, if it were to come back in that -- come back in that way and say, yes, we agree that the State has violated it, and the next step for you, trial judge, is to figure out the remedy. And that could be a year from now, that could be two years from now. And we will be in worse shape than we are right now. Wouldn't you agree?

MR. SHELSON: Yes. Yes, sir, I do. And that's why we are advocating complete relief now, because you are right, Your Honor, just deferring the issues is going to make them worse.

I mean, just to take one example, you know, changes since December 31, 2018, I mean, there's been X changes to date. I mean, two years, whatever, down the road, there is going to be more changes. The system is going to evolve. There's no way to maintain the status quo. The system -- and, frankly, again, you didn't interpret the Court's opinion and order to be, hey, Mississippi, keep doing what you are doing. So, you know, whether it's to DOJ's satisfaction or not is a separate issue, but we have tried.

So consideration number four, Your Honor, "Any relief must be consistent with the fundamental alteration defense." I'm not going to belabor this point, Your Honor. I'm going to try to do this as quickly as I can. This table is the -- the leftmost column is the paragraph in DOJ's plan, the middle column is a service, and the rightmost column is the cost where we could calculate it. So, again, Your Honor, based on the numbers in the record, a second PACT team in Hinds County would cost 600,000. I alluded to this this morning. And 750 additional housing vouchers is 8,000 each, and that's six million a year.

And these other items, Your Honor, it's the State's position that these paragraphs in red are not in the trial record. You know, DOJ is free to dispute that, but our position on things that are not in the record, if we are right about that, from the perspective of the fundamental alteration

defense is that we did not have the chance at trial to price and cost those items. So if we are right that they haven't been raised until now, we had no ability to say, hey, this would cost this much and so forth, and we would have to step up this much to do X and so forth.

So to the extent the State is correct that there's items in the plan, DOJ's proposed plan that aren't in the record, the State just did not have a chance to fairly address those from a fundamental alteration defense perspective.

And all I will do, Your Honor, because we are getting late in the day, I will just read those paragraphs that we think apply, that are not in the record that are in DOJ's plan that has costs associated with them, into the record to move this along. Anyway, paragraphs 22, 26, 29I, 30, 31, 32, 34, 42, if I didn't say it, 47, 48 and 56.

Your Honor, so I think this is what Your Honor wants me to get to. So what relief is Mississippi asking for? Your Honor, we don't think that any remedial relief is warranted beyond the commitments made in Mississippi's report. If the Court orders relief beyond the commitments made in Mississippi's report, we would ask the Court to apply the four considerations I alluded to earlier.

And next, Your Honor, we would ask for complete relief and a final judgment. Again, by complete relief, we mean no issues deferred.

And finally, Your Honor, if the Court issues an order that goes beyond the commitments in Mississippi's report, we would ask the Court to stay that order. But the State -- in that regard, Your Honor, the state would perform the commitments it has made in its report during the period of the stay.

So in conclusion, Your Honor, we urge the Court not to -- not to enter an order that sets the State up for failure by, one, imposing requirements that exceeds the requirement -- that exceed the requirements of the ADA, and two, entering an order that does not contain a clear, specific and objective path to termination. The plans proposed by DOJ and the Special Master, particularly DOJ's plan, exceed the requirements of the ADA and do not contain a clear objective, a clear, specific and objective path to termination.

On the other hand, Your Honor, the commitments made in Mississippi's report are good enough to satisfy the ADA, and the provisions regarding capacity and funding do provide a clear, specific and objective path to termination. So Your Honor, we would ask the Court to say no to the proposals -- to the DOJ's proposal and say yes to Mississippi's report.

THE COURT: Thank you, Mr. Shelson. Ms. Fox?

MS. FOX: Thank you, Your Honor. So a few points in response to Mr. Shelson.

First, the United States does not believe that there's evidence before this Court that the State is truly in

compliance with the ADA. Regardless of the statements that the State has put forth about any changes since trial, we do not believe that Your Honor has evidence before it of the actual provision of services to the people who are at serious risk of hospitalization that reduce the unnecessary hospitalizations in the state. So we do not believe that anything has changed with regard to the finding of noncompliance with the ADA that was made in Your Honor's decision two years ago.

Second, with regard to the fundamental alteration, as Your Honor found in the decision here that the State's scattered and ineffective assemblance of documents did not satisfy the *Olmstead* planning requirement, and all of the experts at trial, both the State's and the United States', found that the cost of services, when looked and compared across the two community and state hospital, were at worst about even. And none of the specific provisions in any of the proposals before the Court changed that general calculus which was made by the parties and by the experts and presented at trial.

Furthermore, as the decision in this matter noted, the case law indicates that budgetary constraints alone are insufficient to establish a fundamental alteration defense. So even to the extent that there are costs that were not anticipated or discussed at trial, again, that would not, in and of itself, establish a fundamental alteration defense on the part of the State.

Finally, I'm ultimately perplexed by the argument that the State doesn't know and that the United States' order doesn't actually provide any information about what is being asked of the State, and it would be completely impossible for the State to actually determine how it would comply or for the Court to make assessments at the end of the day. If you look at the provisions in the proposal that the United States has put forth, even in paragraph 7, which Mr. Shelson highlighted about the increase in mobile crisis teams, there the required increase is in order to comply with the paragraphs above, primarily the requirement in paragraph five, that mobile crisis teams respond within one hour for urban areas and two hours for rural areas. So again, the State would be looking to assess are their teams meeting the timing requirements, and if they're not because they don't have enough staffing, they would have to increase. But there's no moving target here. The target set at trial was timely mobile crisis teams. That's what is laid out here in this order. That is measurable. They can assess are their teams responding in a timely manner, and then, if there is needed, additional staffing to make that timely response, that is what is being assessed here.

THE COURT: How do you measure that? Do you measure that by crisis team or collectively? Statewide, for example, on average, they may be doing it, on average, like this, one hour for urban areas, two hours for rural areas, but it may be

a couple of areas out there, say, rural areas, that are not anywhere touching the two-hour time frame. Would that not -- even if Mississippi is doing it in most parts of the state, but they are not meeting their goal in certain areas, what would the finding be at the end of the day, that Mississippi is meeting that goal or is not meeting that goal because they have got a couple of places that it's just not working?

MS. FOX: I think there's two steps to that to answer. One is, at first, each region would need to be making localized tracking at a localized level and reporting to the State on their timeliness responses. And then under paragraph 7, there would need to potentially be staffing changes if they were not able to meet that because of staffing.

At the end of the day, through monitoring, the monitor would be looking at data from all of the regions. And as the United States understands it, in substantial compliance, as we've had in many agreements around the country, you don't assess substantial compliance by requiring every -- you know, 100-percent compliance with timeliness of every response all across the state. So that would be where there is a role for the monitor and the State and the United States to be setting more specific criteria to permit the State to get to that termination and have a clear sense of compliance. We don't believe that that is necessary to be in the order itself, but that would be then set.

So, yes, it is possible that in one county there could be still challenges with timeliness. First, through the process of monitoring, you would be getting them toward that goal. And then, as a general matter, if they were meeting the timeliness thresholds, that would be the ultimate determination. And there may be a percentage set in the process of monitoring that would help guide that as an objective criteria.

THE COURT: And when you say staffing, I hear quantity more so than quality. I mean, but what if you've just got some poor staffing members on this team that just can't do their job or just don't do their job like they should? I mean, do we get into the meat and bones of the quality of the individuals who are selected by these teams or who are employed by the agency?

MS. FOX: We do not, Your Honor, under the terms here. So looking at the terms that the United States has for mobile crisis, for example, the things that would be subject to monitoring would be that timeliness requirement in paragraph 5. In paragraph 6, an assessment of whether people are transitioned to ongoing services. And then, in paragraph 7, whether there is sufficient staffing to meet paragraphs 5 and 6. So again, we are not getting into the details of quality. We are assessing the order that we have proposed as aimed at what the United States believes was demonstrated at trial to be the key elements of each service. So the key elements --

THE COURT: And you're not -- I'm sorry. And you're not interfering with the State's or MDHS's, or whoever, ability to direct employees, do whatever they need to do to make sure that they meet the ultimate goal of trying to get to the two hours for the rural and one hour for the urban areas?

MS. FOX: Exactly, Your Honor, and that's the entire -- the United States did narrowly tailor its proposal, based on the evidence at trial, to target the key elements of each service that were identified at trial as being those essential ingredients that Dr. Hogan was talking about earlier, and we believe that each of these paragraphs can be monitored. Whether it is as easy as checking a box of, yes, we have funded this, that may not be the case for each, but we do believe that in order to reach ADA compliance, that each of these elements does need to be implemented and monitored. I believe that's all I had.

THE COURT: Oh, no, I'm sorry, I did have a question because I asked him at length about this notion of the possibility of some 54(b) sort of order allowing one phase of this to go forward wherever it needs to go past me while we deal with what the State contends is unopened or left open questions about remedies. What is DOJ's position on the 54(b) sort of question that I asked the State?

MS. FOX: Your Honor, we also believe that we did put on evidence at trial about remedy, and in fact, that we have a

basis for the proposed order that I was just discussing, and that it does specify, in enough detail to be monitored, what the requirements are. So we do not believe at this time that there's a need for a second phase.

THE COURT: All right. Thank you.

Mr. Shelson, I failed to ask this one question. You can answer it from where you are. If the Court -- I didn't ask the State. If the Court were to go with a monitor, is there a maximum amount of time -- I know your minimum amount of time would be a day or two, but is there a maximum that the State -- the government says three years and then one year of full compliance. And I don't want to put the State in a box, but saying that a monitor is a foregone conclusion and that -- but I would think the State disagrees that three years is the point and then one year after that. But is there a period based on what the State has been subjected to in other -- and I know you're not involved in some of the other cases, but obviously the State is, and maybe not in an *Olmstead* context, and I'm thinking of other -- not even cases that are before me, actually. The *Olivia Y.* case, for example, I don't know where it is in the process. I know you had prison conditions cases with me, but that's under a narrow sort of stature of continuing ongoing type of stuff, so -- but is there a maximum amount of time? I won't ask for the minimum, or if you want to tell me the minimum, but what might be the -- if the State has

a position on it, the maximum amount of time? If the Court were to get a monitor involved, what's the maximum amount of time the State would tell this Court to have the monitor present to work on it?

MR. SHELSON: In part, Your Honor, the answer to that question depends on what the criteria were for termination. But assuming that that issue was resolved, assuming that issue were resolved, one year.

THE COURT: Okay.

MR. SHELSON: Because I think if the things that really should be measured were what were on the table, and then there were objective criteria for their satisfaction, then, you know, and you measured at a year's performance, I think the State could do that.

THE COURT: Okay. Thank you.

MR. SHELSON: Yes, sir.

THE COURT: I certainly appreciate the parties for accommodating me today. We started a few minutes earlier thinking that you might be on your way home. But unfortunately, you are not. The Court appreciates the arguments of counsel, and I do -- I think we all do owe a great deal of gratitude to the Special Master in this case so far.

The Court is preparing to take all of this under advisement, and I will just continue with the baseball metaphor that was started earlier this morning, but I saw the highlights

of the Yankees/Astros game last night. The Yankee hitter hits the ball out, home run, I guess. Some time, in some inning, it was 7 to 2. The Yankees were ahead. And as the guy was rounding to third, he pumped on his chest because they were playing the Astros, talking about the wire -- you know, for the baseball fans, Astros allegedly cheated, stole some signs. He patted himself on the chest way too early, because at the bottom of the end of the game, whatever inning it was -- I don't know if it was the ninth inning or some other inning, I think it was the ninth inning -- walk off home run by the Astros, and the guy who was allegedly caught cheating the other year took off his whole jersey.

So I say that to say, you know, we are not at the end of this, but we want to get to the end, and we want to make sure we are not jumping up and down and clapping our hands too early. We want to make the right decision. And I think with these capable lawyers who have been before me and who tried this case before me two years ago -- and I know things have disrupted how we normally would do things with COVID and all of that, and it's unfortunate that the Special Master couldn't really get on the ground here, but I know the parties have worked hard, and I commend you all for being able to reach agreement on the terms that you've been able to reach agreement on. And as I tell you in every case, not necessarily you directly but those who practice before me, in every case, the

case is still in your hands.

I heard all the words that Mr. Shelson was saying, federalism and the Court acting slowly, and I've been sort of trying to do that and to give the parties the opportunity to take care of its affairs. No case is handled in isolation. I know that the State of Mississippi feels like it is flushed with money right now because the State of Mississippi got a lot of Cares Act money. Every state is flushed with money. But that is going to run out. We know that. And we know that the State has to be given the authority to push forward its priorities. And if the State decides that income tax now should be thrown away and we deal with that with the money, that's the State's business, but we have to be able to protect those who cannot protect themselves. It's what I call the least of these. And their voices must be heard throughout these proceedings, and their voices have been heard.

But I commend the lawyers for their work on this case. I just ask that you continue to work with each other and help us get to the appropriate resolution sooner rather than later. It would certainly benefit the public if it's sooner rather than later, if we know where we are going and if we get to the point where we have full compliance, substantial compliance, but compliance in the sense that the persons who need the services are indeed being served.

With having said that, is there anything else from the

United States?

MS. FOX: No, Your Honor.

THE COURT: Is there anything from the State of Mississippi?

MR. SHELSON: No, Your Honor.

THE COURT: All right. Thank you so very, very much for all of your cooperation, all your participation. The Court is now adjourned.

(HEARING CONCLUDED)

CERTIFICATE OF COURT REPORTER

I, Teri B. Norton, RMR, FCRR, RDR, Official Court Reporter for the United States District Court for the Southern District of Mississippi, appointed pursuant to the provisions of Title 28, United States Code, Section 753, do hereby certify that the foregoing is a correct transcript of the proceedings reported by me using the stenotype reporting method in conjunction with computer-aided transcription, and that same is a true and correct transcript to the best of my ability and understanding.

I further certify that the transcript fees and format comply with those prescribed by the Court and the Judicial Conference of the United States.

S/ Teri B. Norton
TERI B. NORTON, RMR, FCRR, RDR
OFFICIAL COURT REPORTER