IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:09-CV-119-CAP
THE STATE OF GEORGIA; et al.	)	
	)	
	)	
Defendants.	)	
_____	)	

DECLARATION OF MICHAEL J. FRANCZAK

Pursuant to 28 U.S.C. § 1746, I, Michael J. Franczak, do hereby declare:

Background and Expertise

1. I am a licensed psychologist and Chief of Operations for Behavioral Health Services at the MARC Center in Mesa, Arizona. The MARC Center provides behavioral health, developmental disability, and vocational services to over 3,000 individual clients. The MARC Center also provides community services to 4,000 adults with serious mental illness and co-occurring disorders through Partners in Recovery, an LLC.

2. I currently serve as an expert consultant to the United States Department of Justice in monitoring the State of Georgia's compliance with a settlement

agreement (the "Agreement") in United States v. Georgia, Case No. 1:09-cv-00119-CAP (January 15, 2009), concerning the seven State Psychiatric Hospitals ("State Hospitals"). Before entry of the Agreement, I served as the United States' expert consultant in its investigation of the State Hospitals.

3. I have extensive experience and professional expertise as both an administrator and a clinician providing behavioral health care services for individuals with serious mental illness, developmental disabilities, and/or co-occurring substance abuse disorders, in both institutional and community settings. For the past 15 years, I have been a senior executive responsible for administering behavioral health services through state and private providers. For five years, I served as the Chief of Clinical Services for the Arizona Department of Health Services, Division of Behavioral Health Services, where I was responsible for the organization, development, and direction of the statewide clinical infrastructure and operations for the Division of Behavioral Services where we served over 90,000 individuals in institutional and community settings.

4. I have served as an expert to a number of court monitors and court special masters overseeing legal agreements governing all aspects of care provided

in both institutional and community settings to residents with developmental disabilities and to persons with mental illness. Examples of such cases include Arnold v. Sarn, No. C-432355 (Sup. Ct. Maricopa Co. 1999), Johnson v. Bradley, No. 99-13458 (M.D. Fla.), U.S. v. Tennessee, No. 92-2062 (W.D. Tenn.), Lelsz v. Kavanaugh, No. 86-1166 (5th Cir. 1987), and New York State Ass'n for Retarded Children v. Cuomo, No. 82-7441 (E.D.N.Y.). I have been accepted as an expert witness in federal court, offering testimony on the issues of behavior management, interdisciplinary process, and applicable standards of care in Jackson v. Fort Stanton Hosp. and Training School, No. 91-2027 (10th Cir. 1992). I have served as an expert witness in numerous additional cases in federal court, although my courtroom testimony was not required in those additional cases.

5. I have authored publications on topics including program accountability, crisis assessment procedures, behavior management, behavior modification, treatment strategies for the dually diagnosed, quality assurance in community services, vocational services, the role of employment in recovery, and integrated mental health and substance abuse treatment. My curriculum vitae is attached as Attachment A.

6. In my role as expert consultant to the Department of Justice in this case, I have examined the treatment and discharge and transition planning services provided to individuals in the State Hospitals, and the availability of services in the community before and after an admission to a State Hospital. My review has included the following:

a. On-site inspections of the following State Hospitals: Georgia Regional Hospital at Atlanta on September 17-21, 2007, Northwest Georgia Regional Hospital in Rome on October 29 through November 2, 2007, Georgia Regional Hospital at Savannah on December 17-21, 2007 and again on June 22-26, 2009, West Central State Hospital on November 30 through December 3, 2009, and Central State Hospital in Milledgeville on November 2-6, 2009 and again on January 11-15, 2010. A representative sample of the interviews and meetings attended and documents reviewed on site can be found at page 109 of the compliance report for the June 2009 Savannah inspection, attached to the United States' Motion as Exhibit 4;

b. Evaluation of the State's policies and procedures, and, as applicable, individual hospital policies, procedures and protocols;

c. Review of the clinical records of hundreds of individuals in the State Hospitals;

d. Interviews with administrators, clinical staff, direct care staff, and the individuals who reside in the State Hospitals;

e. Interviews with the State's Director of the Office of Transitional Planning, and the State's Olmstead Coordinator;

f. Review of summary data and analysis of admissions and readmissions to the State Hospitals, both data generated by the separate State Hospitals and by the State Department of Behavioral Health and Developmental Disabilities ("DBHDD" formerly referred to as the Department of Mental Health, Developmental Disabilities and Addictive Diseases);

g. The State's February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); the January 2005 Study of the CSB Service Delivery System (Phase II); and the May 2005 Georgia Mental Health System Gap Analysis; and survey reports by the Medical College of Georgia from 2007 for each of the hospitals visited;

h. Review of the State's proposed draft Plan of Implementation for the Agreement, and participation in a day-long meeting concerning that plan with the Department of Justice, the attorneys for the State, representatives of BDHDD, and representatives of the Advocacy organizations who have voiced objections to this Court about the deficiencies in the Agreement;

i. The draft proposed Olmstead Behavioral Health Initiative Five-Year Community Finding Plan (December 2009);

j. Interviews with advocates and family members of persons with mental illness in Georgia; and

k. Interviews with the operators of emergency shelters who frequently shelter patients discharged from the State Hospitals.

Individuals Served by the State Hospitals

7. The State Hospitals provide services to persons with serious mental illness, developmental disabilities, and substance abuse disorders. A number of individuals have co-occurring diagnoses of both mental illness and developmental disability. A large number of individuals whose records I reviewed also had a co-occurring substance abuse history. By my estimate, perhaps as many as half of the records I reviewed of persons with mental

illness also had a substance abuse history, which is consistent with data estimates nationally. Many of the individuals served by the State Hospitals have additional physical disabilities or medical concerns. For all of these individuals, participation in major life activities, such as living independently, maintaining a household, holding a job, or taking medication to manage their illness is substantially limited by their psychiatric disabilities. In some cases, these individuals are also limited because others perceive them to be limited by these disabilities.

Expert Opinion

8. My expert opinion, based on my 38 years of experience in the field of behavioral health care and on my review of the systems of care in the Georgia State Hospitals, is that the transition and discharge planning process in the State Hospitals departs substantially from generally accepted professional standards of care, as described more completely below. In addition, the lack of an adequate community service system with a full array of necessary services and supports requires many individuals to be hospitalized to obtain services that can be – but are not – made available to them in a community setting. Thus, individuals with disabilities, including mental illness or developmental disabilities, who desire to live in the

community and whose treatment professionals believe that they can, are not able to obtain the services necessary to live in the community.

Individuals Are Inappropriately Institutionalized

9. Many individuals whose records I reviewed have been institutionalized because sufficient community services were not available to address their needs before admission. The hospitals appear to function as first responders to mental health crises because there appear to be insufficient community and mobile crisis services in the State to stabilize people in crisis without resort to hospitalization. It is my experience that in most states, many of these individuals experiencing short term crises would not have to be hospitalized.

10. There are similarly too few crisis and community support services for individuals with developmental disabilities, many of whom are re-institutionalized due to short-term crises that could have been stabilized in the community. For example, one individual with a developmental disability who had enjoyed a community placement was readmitted to a State Hospital, according to his records, because "there was no where for him to remain in the community" during an investigation of possible caregiver abuse following an incident.

11. Many other individuals whose records I reviewed were admitted repeatedly to the hospital, typically for brief periods, received neither adequate treatment nor adequate discharge and transition planning, and were released, only to be re-admitted in weeks or months. These individuals, often referred to as the "revolving door" population, have typically been institutionalized dozens of times in a period of a few years. Incredibly, many have been re-admitted more than 100 times to the State Psychiatric Hospitals. With adequate treatment and discharge planning, and with expanded availability of services in the community, this cycle of needless repeated institutionalization could be avoided. The individuals caught in the revolving door of repeat admissions are at significant risk of harm, both from the aggression and self-injury so prevalent in the State Hospitals, but also because repeated cycling in and out of crisis and in and out of the hospital can make their illness more intractable to treatment.

12. Institutionalization is stigmatizing. It is also extraordinarily disruptive of relationships, employment, school and all aspects of building a life in the community to be unnecessarily institutionalized.

13. All individuals inappropriately institutionalized face ongoing and significant harm. Many of those who are institutionalized and deprived of their liberty

do not receive necessary and appropriate care. Finally, all patients in the State Hospitals face a significant risk of bodily harm from assault and self-injury that is so prevalent in the State Hospitals.

The State Has No System to Ensure That Individuals Receive Services in the Most Integrated Setting Appropriate to Their Needs

14. The State's process for identifying patients able to transition from the State Hospitals is needlessly cumbersome and fundamentally flawed. The State's policies do not require systematic evaluation of all individuals in the institutions to ensure that they are being served in the most integrated setting appropriate to their needs unless they have been institutionalized for 60 days or longer. The way the process works in Georgia, the State begins developing a transition plan only after an individual's treatment team identifies him or her as appropriate for treatment in a more integrated setting. This system is exactly backwards. To ensure that individuals receive care in the most integrated setting appropriate to their needs, it is important to begin to identify, as soon as possible after admission, the specific community resources that are needed to support the individual in a more integrated setting. That is accomplished by creating an interdisciplinary transition plan. Tracking how long individuals wait in the State Hospitals before they are placed on the list to be transitioned to the

community can also force accountability for needless delay – but in Georgia, the State does not systematically track, analyze and report this data.

15. Individuals with mental illness face a double barrier to discharge under this systemically flawed process. Many individuals with mental illness, particularly those who are repeatedly admitted for very short lengths of stay, may never receive an interdisciplinary review centered on what supports and services are required to support them in a more integrated setting because the State does not require such a review until the individual has been hospitalized for 60 days.

16. The State has determined, as a matter of policy, that all persons with developmental disabilities can be served in the community or a more integrated setting than the State Psychiatric Hospitals. The State's Director of the Office of Transition Services stated that, unless a person with a developmental disability or his or her family objects, they are placed on the Olmstead lists right away. Many individuals with developmental disabilities, however, have spent additional months and years waiting to be placed in the community after being placed on these lists.

17. In my experience, all of the individuals I have described, including those with developmental disabilities or with mental illness, those who have been

institutionalized for long periods, and those who make up the "revolving door" of frequent admissions, could be served successfully in the community with a range of community-based supports and services typically available in other states.

Discharge and Transition Planning Services at the State Hospitals Depart Substantially From Generally Accepted Professional Standards

18. The discharge and treatment planning services provided to patients in the State Hospitals are systemically flawed, and depart substantially from generally accepted professional standards. The State Hospital System does not set a uniform standard for quality of care. Although policies espouse a person-centered philosophy of care, in fact, the care provided across the system is based on an antiquated model of care that is not recovery oriented and in many cases fragmented by the lack of community resources and poor coordination between institutional and community care. Training and quality assurance is deficient and fails to detect and correct overwhelming instances of substandard care.

19. Accurate assessments are needed to identify the reasons that individuals have been hospitalized and to guide treatment interventions, particularly in the case of those individuals readmitted after a prior admission and discharge. Yet assessments I reviewed are frequently generic and

incomplete and fail to result in a comprehensive or coherent case formulation. Assessments from different disciplines are often contradictory, and differences are not resolved by the treatment teams because the teams do not function in an interdisciplinary manner.

20. Treatments are not adequate to address the needs of individual patients. The State Hospitals provide the majority of treatment interventions in treatment malls, or, for individuals with developmental disabilities, in training centers on the grounds of the Hospitals. Having reviewed these programs at each of the hospitals visited, it is my opinion that treatment is woefully inadequate to address the needs of individuals in the State Hospitals, and falls substantially short of generally accepted professional standards. The barriers to successful community living are not routinely addressed in treatment for any of the populations served by the State Hospitals. Treatment seems to be based primarily on what groups are available, and not on what skills individuals need to learn to facilitate their recovery and prepare them for life outside the hospital.

21. Staff need training in critical areas, including person-centered treatment planning that supports development of an integrated treatment plan. Individuals in the State Hospitals with acute psychiatric needs typically

receive only the most generic interventions and treatments, primarily focused on medication stabilization. Groups and interventions are not aligned with the recovery model that the State professes to be its model of care. There is a need to focus on developing skills, and on identifying strengths of the person to build upon. A treatment plan I examined at one hospital stated simply, "this patient has no strengths."

22. There is an egregious lack of substance abuse treatment for individuals who have a history of substance abuse, both in the State Hospitals and in the community. Individuals with a history of substance abuse are among those patients who are frequently re-admitted to the State Hospitals and they represent a significant portion of the individuals treated in the State hospital setting. For example, one individual at GRHS with a history of mental illness and cocaine dependence had been admitted more than 100 times to the State Hospitals, typically for very short periods of several days. His discharge plan was that "He will go wherever he goes," and his prognosis was: “Expect a repeat of this situation in a week.”

23. Treatment teams do not engage in person-centered planning. The individual's desires, and those of his or her chosen representative, are not central to the treatment or discharge plan. The State Hospitals fail to engage

family members or significant others in the treatment planning or discharge process. I saw no evidence that family members who could provide the needed natural supports for individuals living in the community are provided with educational materials or supports to assist their loved ones upon discharge.

24. A Repeat Admissions Review Coordinator ("RARC") has been established at several of the hospitals that I visited, and the RARC has begun to identify forms and processes to guide the review of patients re-admitted to the Hospital after a prior admission. Nonetheless, the use of information about reasons for re-admission remains substantially deficient. For example, at CSH, where the RARC has identified processes and provides helpful reports to treatment teams, the information presented by the RARC does not influence treatment planning in 60% of the cases reviewed.

25. A central principle of transition planning is ensuring continuity of care from the hospital to the community. However, the State Hospitals fail to document sufficient efforts to engage community providers in developing a transition plan, or to connect individuals with community services prior to discharge.

26. Policies at the State Hospitals, for example, Central State Hospital ("CSH") Policy 4.31, address Continuity of Care and Transition Planning. This policy requires the State Hospital to make only minimal efforts to engage the community in the discharge process, which severely compromises the quality of care provided upon discharge. Minimal, and frequently, non-existent participation of community providers results in transitions where individuals have had no prior contact with the community provider, in violation of generally accepted professional standards. I also saw no indication in any of the records of persons re-admitted to CSH that the Hospital maintained communication with the providers or the individual after discharge to the community.

27. The State Hospitals do not provide adequate information about the individuals who have been under their care to community providers at the time of discharge. The State Hospitals should exist as part of a continuum of care, and must transfer the information they gain about hospitalized individuals, their strengths, needs, learning styles and preferences, to the community providers who next provide care. To the individual patient, the transition from institutional to community care should be seamless.

28. The State Hospitals continue to discharge large numbers of individuals to night shelters, transportation terminals, and the public buildings and streets, although these and other similarly inappropriate settings lack the necessary programs to support individuals with serious mental illness or substance abuse problems. I have spoken with the operators of shelter programs who assert that individuals discharged from the State Hospitals typically arrive without any advance notice or a phone call from the Hospital. Discharged patients arrive with no support other than a short term prescription for anti-psychotic medications. The shelter operators with whom I spoke were willing to provide shelter, but noted that they did not, and could not, provide the supports and services often needed by a person with serious mental illness, including services such as assistance in taking medication or managing medical and mental health care appointments.

29. I have seen no documentation to suggest that the State Hospitals adequately counsel individuals or sufficiently describe or offer appropriate alternatives to individuals who choose discharge to a homeless shelter.

30. Inappropriate discharges place the affected individuals at risk of significant harm. In one case last fall, an individual who was three months pregnant was discharged to a homeless shelter, with multiple prescriptions but no

connection to a medical care provider or other necessary behavioral supports. In a second case, an individual with ten prior admissions to the State Hospitals was discharged to a shelter. Within two days he apparently took an overdose of medication, possibly as a suicide attempt. On readmission to the State Hospital, he made clear his pressing needs: he did not want to go back to a shelter, and needed the Hospital to help him find a place and fix his social system.

31. I saw little documentation to suggest that the State Hospitals take sufficient steps to educate family members or personal guardians who object to community placement about positive outcomes and choices available in the community. Generally accepted standards require education of individuals and their personal representatives to overcome opposition based on outdated or mis-information about the choice of services that are currently available to support an individual in more integrated settings.

32. Typically, Social Workers in the hospitals asserted to me that choice counseling and family education is done by case expediters or other staff who work for the Regional Offices of DBHDD. Yet the State Hospitals could offer no documentation to support that assertion. In individual cases I discussed with hospital Social Workers, it was evident that long delays in

placement occurred because State or Regional Office employees and others outside the Hospital's control failed to follow up as promised. In many instances, it appeared that community placements were not identified as promised, and in other cases, it appeared that opposition from family or personal representatives was not addressed and overcome. The result is that individuals who have been identified by treatment professionals as appropriate for community placement remain hospitalized for long periods following that determination.

There is an inadequate array of community services

33. Because the State has failed to develop and fund an adequate array of community services, individuals with serious mental illness, developmental disabilities and/or substance abuse disorders in the State of Georgia continue to be confined unnecessarily.

34. The audits done by the State of its community service boards pointed to significant gaps in necessary services and a lack of accountability in the community system.

35. Insufficient supported housing opportunities in the State result in individuals having to reside in inappropriate settings that do not support their recovery and their return to the community.

36. The State's lack of assertive community treatment or intensive case management services causes individuals to have to be hospitalized when they are not adherent to their medication regimes. These services, which are inadequate in Georgia, are effective because they can improve medication adherence and prevent hospitalization. An intensive staffing ratio of 1:12 allows more intensive supervision for persons who require this level of care. An assertive community treatment ("ACT") team typically costs at least $1.2 million for one year. It was clear from my review of records that many individuals with mental illness in the State Hospitals need assertive community treatment upon discharge, but do not receive this service. Professional staff at each of the hospitals I visited agreed that there are insufficient ACT teams to serve the people who need them.

37. There is an inadequate array of community crisis intervention services and mobile crisis intervention services to address short-term intensive needs and allow individuals to remain in the community instead of being hospitalized.

38. Although the State has a nationally-acclaimed model of peer supports, this service is not routinely available in the hospital or community.

39. There are very limited day treatment or partial-hospitalization programs that provide individuals with the skills needed to be successful in the community.

40. There are vastly insufficient vocational services and supports that would allow individuals to gain self-esteem by becoming productively employed members of their community.

41. Unnecessary and prolonged institutionalization harms the individuals who are confined. Being confined to an institution is extraordinarily disruptive of life in the community, of personal relationships, of living arrangements, and of employment. In addition, repeated admission without successful treatment can worsen an individual's illness, as research shows that frequent relapse and re-admission may make an individual more intractable to treatment.

Cost of Providing Services in the Community

42. In my experience, providing services to support a person with mental illness or a person with a developmental disability living in the community costs substantially less than providing services in an institutional setting. The figures used in Georgia's draft Olmstead Behavioral Health Initiative Five-Year Community Funding Plan support this, suggesting a cost savings of more than $13,000 per person when serving a person with mental illness in the community.

Keeping Individuals Safe

43. Individuals in the State Hospitals – including the many individuals who should never have been hospitalized and for whom the hospital is not the most integrated setting in which to receive care – face an ongoing risk of serious harm. At each hospital, lengthy lists of incidents involving assaults and injury were provided to the expert team. Both victims and aggressors on these list are suffering harm – the aggressors, because they are denied competent and effective care to address the symptoms of their illness, and the victims, by their injuries. There is no system in place to ensure timely and effective intervention when patients engage in repeated or escalating episodes of aggression or self-injury. Staff do not display competency in using generally accepted techniques to modify challenging or dangerous behaviors, including the use of functional behavioral analysis and positive behavioral supports. There is insufficient evidence-based treatment provided at the State Hospitals, and insufficient trained staff to provide it.

44. I am aware that the settlement agreement between the United States and the State requires substantial efforts to reduce patient assaults no later than January 15, 2010. During my visit to CSH from January 11-15, new state-level risk management policies were described that would create a system to detect individuals with escalating signs and symptoms of

aggression and other behavioral concerns, and require treatment teams to address those concerns. There is no evidence that the system has been implemented.

45. Staff are not trained adequately to implement the new policies described to the DOJ team on our visit to Central State Hospital ("CSH") in January. I interviewed the director of staff training at CSH, and requested the plans developed to train all employees in the coming months, including all plans for training on the revised policies. The training plans are not sufficient to

address the significant training needs evident at CSH and in each of the hospitals I visited, and certainly not within the promised time frames.

* * * * *

The foregoing is based on my professional expertise, and also my personal knowledge of conditions and policies governing treatment planning, and discharge and transition planning at the State Psychiatric Hospitals, gained through my examination of documents including clinical records, my observations, and interviews with hospital staff, patients, and administrators, State administrators and employees, and community- based service providers.

I certify under penalty of perjury that the foregoing is true and correct.

Executed this 28th day of January, 2010.

MICHAEL J. FRANCZAK

Attachment A

R E S U M E

MICHAEL J. FRANCZAK, Ph.D.
9124 East Maple Lane
Scottsdale, Arizona 85255
(480) 473-3397

EDUCATION:

1974-1976	Saint Louis University, Saint Louis, MO Ph.D. in Psychology May 1976
1972-1974	New School for Social Research, New York, NY
1971-1972	Montclair University, Montclair, NJ M.A. in Psychology, December 1972
1967-1971	LaSalle University, Philadelphia, PA B.A., May 1971, Major: Psychology

PROFESSIONAL ACTIVITIES

December 2006 to Present:
Chief Operations Officer for Behavioral Health Services, Marc Center Mesa, Arizona.

In this position I am responsible for the organization, development and direction of services for individuals who receive behavioral health services through Marc Center. Marc Center has been in existence since 1957 providing behavioral health, developmental disability and vocational services to both children and adults. The Marc Center behavioral health program provides residential, independent living, outpatient services, vocational services, in-home and recovery supports. We have a staff of over 300 who provide these services 24/7. Our current budget is approximately $14,000,000. Due to our wide variety of services and excellent national reputation, Marc Center serves as a training site for Council for the Accreditation of Rehabilitation Facilities (CARF) Reviewers.

February 2001 to November 2006:
Chief of Clinical Services, Arizona Department of Health Services, Division of Behavioral Health Services, Phoenix, Arizona.

In this position I was responsible for the organization, development and direction of the statewide clinical infrastructure and operations for the Division of Behavioral Health Services. The total budget for the Division is approximately $950,000,000. Clinical operations include the Bureau's for Adult Services, Children's Services, Substance Abuse Services, Prevention, Training, Customer Services and Network Management. Responsibilities include the management of the programmatic monitoring and oversight of the Regional Behavioral Health Authorities (RBHA) to ensure compliance with state and federal programmatic requirements, standards and guidelines; development, monitoring and implementation of corrective action plans; developing budgets and monitoring clinical services expenditures; coordination of activities among Division clinical bureaus and other offices of the Division of Behavioral Health; provision of training, technical assistance and consultation to the RBHA; development of clinical policies and procedures to ensure compliance with federal and state regulations; development and monitoring of transition and discharge processes from State and Local Psychiatric facilities to the community behavioral health system including admissions and readmissions, development of reports for and testimony at Legislative hearings, writing federal grants including the State Block grant and other competitive grants, serving as the Chairperson for statewide committees on Olmstead Planning, Best Practices, Stigma Reduction, Assessment and Evaluation, Data Integrity, Clinical Services, Co-Occurring Disorders, and Network Analysis and Development.

January 1995 to February 2001:
Chief, Bureau for Persons with Serious Mental Illness, Arizona Department of Health Services, Division of Behavioral Health Services, Phoenix, Az.

In this position I managed the services provided by the Bureau for Persons with a Serious Mental Illness. The Bureau monitored services for 22,000 individuals throughout the State of Arizona. In this position I was responsible for the development, implementation and monitoring of a community system of care including the transition and discharge process from State and Local Psychiatric facilities to the community behavioral health system including admissions and readmissions. The Bureau activities included oversight of contract performance, implementation of system improvements, provision of technical assistance and training and coordination of a variety of grant activities. The Bureau was involved in the Division of Behavioral Health's Planning Councils, a variety of work groups including Jail Diversion, Social Security Work Incentives, and a variety of consumer and recovery support activities.

July 1991 to December 1994:
Senior Research Associate; Improvement Concepts Incorporated; Raleigh, NC

In this position, I served as the manager of Improvement Concepts (ICI) North Carolina office from which evaluations of potential Thomas S. class members were organized and conducted. ICI was appointed as the Independent Evaluator by the Federal District Court for the Thomas S. case. The class membership was estimated to be 2,300 individuals, the majority of whom lived in State Mental Hospitals, Nursing homes, Group Homes, ICF/MR's and Private Boarding Homes. The potential class members were individuals who have a mental health and mental retardation diagnosis and had received treatment in mental health settings operated by the state of North Carolina. In this position I developed and tested evaluation instruments, trained and supervised the independent evaluators used in this case. The evaluation instruments were based on relevant HCFA regulations, ACDD standards, and state and federal regulations. The evaluations resembled internal quality assurance reviews and focused on habilitation, living conditions, medication practices, and behavioral interventions. A large section of the evaluations included recommendations to improve services for the individual based on the requirements of the court order. There were at least 40 independent contractors conducting evaluations. I also provided follow-up on the review and disposition of the evaluations and testimony as necessary.

November 1990 - July 1991:
Director of Planning, Evaluation, and Development/Quality Assurance; Western Center; Canonsburg, PA

In this position, I directed the facility quality assurance and professional services program. I was assigned by the Pennsylvania Director of Health Services to Western Center which served individuals with developmental disabilities and behavioral health issues on an emergency basis following financial sanctions that were placed on the facility by the Health Care Finance Administration. My job was to get the facility back to full licensure. Within six months, the facility received a full license and had all sanctions removed. Following the emergency assignment, I remained at the facility in order to further structure their quality assurance program to ensure sustainability. Full license was attained and maintained during my tenure at Western Center.

June 1983 - November 1990:
Director of Planning, Evaluation, and Development/Quality Assurance; Laurelton Center; Laurelton, PA

Laurelton Center provided services to children, adolescents and adults with developmental disabilities and behavioral health disorders and served as the site for regional special education program that served children living at Laurelton, with family and in other residential settings in the Central Pennsylvania region. In this position, I directed and reviewed all aspects of the facility's quality assurance activities. This included program management audits, internal compliance reviews, privacy audits, safety inspections, infection control inspections, supervisory inspections, QMRP reviews, and discipline reviews. I was also responsible for the monitoring and follow-up of all Plans of Correction. As the Chairperson of the Quality

Assurance Committee, I was responsible for the coordination of internal facility reviews, which were based on current ICF/MR and ACDD standards. Other duties included the direction and supervision of Discipline Coordinators for Psychology, Social Services, Speech and Hearing, Cognitive Development, Recreation, Staff Development/Program Evaluation and the Client Records Department. Facility training activities were designed, conducted, evaluated, and documented in a manner that met ICF/MR, ACDD, and DPW requirements. During this period I served as the lead manager in Laurelton Center's effort to achieve accreditation from ACDD. ACDD accreditation was achieved in 1989.

I was also responsible for managing our Regional Resource Program, which provided services to the 11 counties in our catchment area. While these services included the full range of discipline specialties, the majority of requests were due to severe behavior and/or emotional problems. In addition to managing the overall program, I served as the primary behavioral consultant on these issues. During this period I also evaluated services at other state facilities and conducted at least 20 facility reviews. I served as a consultant on ACDD standards and behavior management programs to other facilities throughout Pennsylvania.

October 1976 - May 1983:
Chief of Psychological Services; Selinsgrove State School and Hospital; Selinsgrove, PA

During this period, I was responsible for organizing and coordinating Psychological Services at Selinsgrove State School and Hospital. The position involved the development of department policies and procedures and the training of all Psychological Services staff. I was also involved in institution-wide program evaluations with respect to ICF/MR licensing and ACMRDD accreditation standards. Duties included coordination of the Psychological Services staff through individual and group meetings in an effort to gain consistency in institutional policies and behavior management practices and to provide adequate training for Psychological Services staff. Also included was the direction of the Intensive Treatment Team, a group of four staff members assigned to conduct behavior management programs that required one-to-one coverage for adequate implementation. During this period, I also developed and served as the psychologist for the Social Skills Center, an area that was designed for clients with dual diagnoses with severe behavioral and emotional disturbances. I was responsible for the State of Pennsylvania's first Behavior Management Policy and conducted trainings and consultations on the policy statewide.

September 1973 - July 1974:
House Parent; Wiley House -Residential Care for Emotionally Disturbed Children, Bethlehem, Pa.

I was a house parent in a cottage that provided temporary living arrangements for emotionally disturbed children and adolescents. Activities included basic care, counseling, crises management, educational, recreational and social support. Wiley House provided a variety of living options including residential, respite, foster care and family support. It also provided a full educational program. I worked the afternoon shift as a House Parent so that I could attend graduate psychology classes.

August 1972 - September 1973:
Counselor; Kensington Rehabilitation Center, Philadelphia, Pa.

In this position I served as a mental health and substance abuse therapist/counselor for adolescents and adults with severe addictive disorders... Duties included conducting daily group therapy sessions, vocational training and counseling and individual supportive therapy. The majority of individuals were placed in the facility by the penal system as part of their probation or parole requirement. Other individuals were placed by their families when living in their natural homes became too stressful for the family.

SPECIAL PROJECTS

June 2007- Present US Department of Justice, Civil Rights Division, Washington, D.C.

I serve as a consultant and expert witness for DOJ in their evaluation of the Georgia and Oregon Psychiatric Hospitals implementation of the Olmstead Order regarding admission, care, transition and discharge from psychiatric hospitals.

January 2007 – March 2008 Bazelon Center, Washington, D.C.

I served as a consultant and expert witness for the Bazelon center on an investigation of admission, care and discharge planning for individuals with mental and psychiatric disabilities who live in Nursing homes in San Francisco, California.

June 2004 – July 2007 Human Systems and Outcomes, Tallahassee, Fl.

I served as a consultant on the review and development of the State of Indiana Adult and Children's system of care. I performed reviews of community behavioral health services in numerous counties throughout the state.

May 2002- May 2007 Human Systems and Outcomes, Tallahassee, Fl.

I served as an expert in the review of community behavioral health services provided by the District of Columbia Mental Health System and St. Elizabeth's Hospital. In this role I examined cases and developed reports for the Defendant and Court Monitor.

March 2002 - April 2002 Department of Justice: Verlin Deerinwater, Washington, D.C.

I served as an expert for the United states Department of Justice at the Hawaii Community Mental Health Summit. The Community Summit was held in March 2002. Membership included three representatives appointed by the State of Hawaii; three representatives appointed by the United States Department of Justice; a representative appointed by the Court; and a facilitator and recorder appointed by the Court. Our purpose, as defined by the Court was to, "address the provision of adequate and appropriate mental health services to individuals who have been diverted, transferred and or discharged from Hawaii State Hospital, and propose a plan to implement a system for the delivery of community-based mental health services that address the clinical and social needs, meaning social services including housing, vocational and case management, of individuals who have been or currently are patients or residents of Hawaii State Hospital."

December 2001-January 2004 Department of Justice: Aileen Bell, Washington, D.C.

I served as an expert consultant in a review of the Laguna Honda Hospital in San Francisco, which is a facility that provides skilled nursing services to individuals with disabilities. The issue under review was the facilities compliance with the federal Olmstead Decision.

November 2001 Gains Center: Hank Steadman, Ph.D., Delmar, New York

I provided technical assistance for the Gains Center at an orientation program for Federal SAMHSA grant recipients for grants designed to increase service capacity in the areas of jail diversion and co-occurring disorders.

August 2001 Rand Corporation, Santa Monica, California

I served as an expert consultant for the Rand Corporation as they were researching best practices in the area of treatment for individuals with co-occurring mental health and substance abuse disorders.

April 2000-December 2001: Linda O'Neal, Ph.D.; USA vs. State of Tennessee

I served as a member of an interdisciplinary panel of experts that were assembled to review the compliance of the Arlington Developmental Center with the stipulations of a remedial order. During this review my focus was psychology, habilitation, behavior management, and restraint/seclusion practices.

January 1998-1999 Florida Department of Children and Family Services Expert Panel, Human Systems and Outcomes, Inc., Tallahassee, FL.

I served as a member of a six person expert panel that was constructed to review the Florida Department of Children and Families developmental disabilities service individualized planning process. The panel reviewed a sample of cases and interviewed staff from all levels of the organization. The panel presented findings regarding the current status of the process and made recommendations for improvement.

June 1994-July 1999: Independent Evaluator; Halderman, et al. v. Pennhurst State School and Hospital, Philadelphia, Pa.

In this case I organized and managed the activities of independent evaluators who were assigned to review the records of 550 class members. The evaluation focused on the status of the medical records and the use of anti-seizure and psychotropic medications. The evaluators were general practice physicians, psychologists, neurologists and psychiatrists. I authored reports based on the evaluation results and served as an expert witness in the evaluation of behavioral health services to class members of the Romeo Lawsuit.

May 1992-June 1994: Office of the Monitor; Johnson v. Bradley, Tallahassee, FL.

My role in this case was to provide evaluations of Service Plans that were then used to determine the reliability of the G. Pierce Wood Internal Quality Assurance Audit Process. An instrument was developed by the Office of the Monitor and was utilized to determine compliance with the Court Order. My evaluations were compared with those conducted by the facility staff in order to determine inter-rater reliability.

February 1994- March 1994: Expert Witness: Felix v. Waihee; Honolulu, Hawaii

In this case I served as part of a team of expert witnesses for the evaluation of the community services received by children and youth throughout the state of Hawaii. The individuals lived in a variety of settings from family homes to the Youth Detention Center. The purpose of the evaluation was to determine if the children were receiving adequate educational, developmental disabilities and mental health services. I also participated in the development of the final report for the plaintiffs that included recommendations for the improvement of services for the individuals and the system at large.

June 1992 - August 1994: Office of the Monitor; Superior Court of Arizona; Phoenix, AZ

On this project, I worked for the court appointed monitor and served as an evaluator of the community mental health services provided by the Arizona Department of Health, Division of Behavioral Health which were subject to review based on the Arnold vs. Sarn court decision. An instrument that was developed by the Office of the Monitor was utilized to determine compliance with the Court Order. The evaluation included recommendations for the improvement of services for the class members.

January 1990 - April 1990: New Mexico Protection and Advocacy System; Albuquerque, NM

I served as a consultant in the areas of ICF/MR regulations, ACDD standards, interdisciplinary process, and behavior management. I participated in the review of two state facilities and served as the expert witness in the Jackson v. Fort Stanton and Los Lunas State School and Hospital case.

August 1989 - November 1991: Advocacy Center; Tallahassee, FL

I served as a member of a review team developed to examine services in the Florida mental health system. In this role, my specialty was behavior management techniques and interdisciplinary team process in the use of psychotropic medications. The reviews include a comprehensive examination of program planning, implementation, empowerment, individual rights, and health care.

January 1988 - July 1994: Therapeutic Resources (self-employed); Woodward, PA

This is a position with a private firm that provided the following services to community and institutional programs: behavior management, quality assurance, staff training, vocational, speech, hearing, recreation, cognitive development, assessment, and referral. In this role, I provided behavior management services to

several families, group homes and community facilities. I was also involved in staff training in which I provided in-service training on behavior management, quality assurance, relaxation techniques, developmental programming, and the treatment of individuals with dual diagnoses. I also participated in evaluations in the following cases: Connecticut Traumatic Brain Injury Association, Inc. v. Michael Hogan, et al. and specialized evaluations in individual legal cases.

October 1987 - July 1991: Office of the Special Master; Willowbrook; New York, NY

In this position, I served as part of an audit team that was developed to review New York facilities that are subject to the NYS ARC v. Cuomo class action suit and the subsequent Willowbrook Consent Decree. The audit focused on habilitation, behavior management, the environment, assessment, team process, staff training, and other issues. I had the opportunity to audit several New York facilities over the years. My specialty during these audits was behavior management techniques and psychological services. I have also served as a consultant to the Special Master's Office in the areas of quality assurance, ICF/MR regulations, and vocational services and have generated recommendations for the correction of various problems found at facilities.

September 1987 - January 1993: Therapeutic Concepts, Inc., Winter Park, FL

In this position, I served as a consultant to Therapeutic Concepts, an organization providing managerial and programmatic assistance to Hissom Memorial Center in Oklahoma and other facilities throughout the country. My specific role was that of an evaluator in an ongoing review of client habilitation. Duties included the review of the habilitation plan development and implementation. While employed by Therapeutic Concepts, I also served as an evaluator in the following cases: Homeward Bound v. Hissom Memorial Center, Jackson v. Los Lunas and Fort Stanton, and Bogard et al. v. Illinois.

August 1986: L. R. O'Neal Associates, Tallahassee, FL

In this position, I was involved in the review of facilities in the state of Texas as part of the Lelsz v. Kavanaugh class action suit. Review procedures consisted of a highly structured audit of active treatment programs, program documentation, the interdisciplinary process, and the environment. The results of the reviews have been utilized as ongoing data in the resolution of a suit filed in the United States District Court.

ACADEMIC EMPLOYMENT

2006- Present Arizona State University

Serve as an adjunct faculty member supervising doctoral and pre-doctoral psychology internships.

1979 - 82: Susquehanna University, Selinsgrove, PA

At Susquehanna, I taught courses in Developmental Psychology, Developmental Disabilities, Behavior Therapy, History and Systems of Psychology, and Introduction to Psychology.

1975 - 1976: Saint Louis University, Saint Louis, MO

As a graduate fellow, I taught sections of Physiological Psychology and Learning Theory to graduate and undergraduate students.

1976 - 1977: Parks College of Saint Louis University, Cahokia, IL

I taught General Psychology to undergraduate students.

PROFESSIONAL LICENSE

Licensed Psychologist - PS-002960-L

By the Pennsylvania Commission of Professional and Occupational Affairs

PRESENTATIONS AND PAPERS

1973 An examination of Predictions Concerning the Recall of Verbal Isolates
Eastern Psychological Association Convention, Washington, DC

1974 The Behavior Modification Training Manual
Copyright Pennhurst Center, Spring City, PA

1974 Autoshaping as a Function of the Similarity to the Consummatory Response
Psychonomic Society, Denver, CO

1976 Behavioral Interactions in Fixed-trial Response Independent Reinforcement Procedures
Midwest Association for Behavior Analysis, Chicago, IL

1976 An Application of DRO Procedures with the Profoundly Retarded Adults
Midwest Association for Behavior Analysis, Chicago, IL

1977 Program Organization within a Unitized System
American Association of Mental Deficiency, Baltimore, MD

1978 The "Relativity of Reinforcement" Principle
Gatlinburg Conference, Gatlinburg, TN

1978 A Variation of Required Relaxation for Use with Severe Disruptive Behavior
Eastern Psychological Association, Washington, DC

1978 Program Organization and Accountability within a Large Residential Institution
Pennsylvania Psychological Association Convention, Lancaster, PA

1978 Symposium on Behavioral Procedures
Pennsylvania Association for Research in Mental Retardation, Selinsgrove, PA

1978 An application of Premack's "Relativity of Reinforcement" Principle in the Reduction of Inappropriate Behaviors. American Association of Mental Deficiency, Rehoboth Beach, DE

1979 A Comparison of Maladaptive Behaviors in Seizure and Nonseizure Clients
Gatlinburg Conference, Gatlinburg, TN

1979 An Examination of the Additivity Theory of Behavior Contrast
Eastern Psychological Association, New York, NY

1980 Effects of the Number of Clients per Living Unit on the Rate of Aggressive/Destructive Behaviors, Gatlinburg Conference, Gatlinburg, TN

1980 Institutional Ecology and its Effects on the Mentally Disabled
Pennsylvania Chapter, American Association of Mental Deficiency, State College, PA

1982 Prescriptive Behavioral Assessment: An Alternative to Restrictive Procedure Hierarchies,
Region IX AAMD Conference, Williamsburg, VA

1983 A Mechanism to Increase the Density of Reinforcement in Institutional Settings
Region IX AAMD Conference, Williamsburg, VA

1984 Effects of a Response-Active Environment
PA Chapter AAMD Conference, Hidden Valley, PA

1984 Autoshaping Attending Behavior
Region IX AAMD Conference, Williamsburg, VA

1984 An Interdisciplinary Crisis Assessment Procedure Designed to Reduce Restraint/Exclusion Usage, AAMD Conference, Scranton, PA

1985 Comparative Effects of PUSH Modular Play Units and Traditional Strategies
National AAMD Conference, Philadelphia, PA

1985 Behavior Management and Training of Persons with Severe and Profound Mental Retardation, National AAMD Conference, Philadelphia, PA

1985 A Binary Token System, PA Chapter of AAMD Conference, Harrisburg, PA

1986 Psychopharmacology and Behavior Management, Hamburg Center, Reading, PA

1986 Pennsylvania Office of Mental Retardation Behavior Management Policy

1986 The Behavior Management Policy Video
Pennsylvania Office of Mental Retardation

1988 Pennsylvania Office of Mental Retardation Behavior Management Policy - Update

1990 A Holistic Approach to Physical and Mental Wellness
Community Positive Approaches Conference, Harrisburg, PA

1991 Conducting an Environmental/Functional Analysis
Facility Positive Approaches Conference, Carlisle, PA

1992 Issues in the Thomas S. Lawsuit
North Carolina Association for Behavior Analysis Conference, Greensboro, NC

1994 A Method to Analyze Injuries Caused by Inadequate or Inappropriate Treatment
National Association of Protection and Advocacy Systems, Washington, DC

1995 Quality Assurance in Community Services
North Carolina Community Services Providers Conference, Raleigh, NC

1995 Treatment strategies for the Dually Diagnosed
North Carolina Community Services Providers Conference, Raleigh, NC

1996 The History of Managed Behavioral Health Care
Pennsylvania Association for Supported Employment, Harrisburg, PA

1996 Case Management and Vocational Services
Pennsylvania Association for Supported Employment, Harrisburg, PA

1996 The Incentives of Managed Behavioral Health Care
University of Arizona, Phoenix, AZ

1997 Models of Case Management in Managed Care
University of Tennessee, Chattanooga, TN

1997 The Challenge for Vocational Services in Managed Behavioral Health Care
University of Tennessee, Chattanooga, TN

1998 The Role of Employment in Recovery
Value Options Recovery Conference, Phoenix, AZ

1998 Advances in Integrated Treatment
Arizona Mental Association Conference, Phoenix, AZ

1999 Developing Community Consensus on Best Practice Models
Philadelphia Coordinated Health Care, Philadelphia, PA

1999 Integrated Mental Health and Substance Abuse Treatment
Arizona Rural Health Conference, Honda, AZ

1999 Advances in the Treatment for Co-occurring Disorders
Arizona Mental Health Providers Association

1999 Principles of Integrated Treatment
Arizona Mental Health Association Conference, Phoenix, AZ

2000 Models for Building Community Consensus for the Implementation of "Best Practices".
Gains Center Conference, Miami, Florida

2000 Consensus Models in Building Jail Diversion and Integrated Treatment
Innovations in Forensic Mental Health, New York University, New York, NY

2000 Systems Change to Improve Treatment Models for Co-Occurring Disorders
State Mental Health Program Directors Meeting, Minneapolis, Minnesota

2000 Integrated Mental Health and Substance Abuse Services.
Arizona Substance Abuse Consortium, Prescott, AZ

2000 Creating Jail Diversion Programs, American Society of Criminology Conference, San Francisco

2000 Collaboration between Crisis Services and Jail Diversion, NASMPD Forensic Division, AZ.

2001 Treatment Guidelines for Co-Occurring Disorders, Arizona Substance Abuse Research Consortium, Honda, AZ.

2001 Arizona Initiative to Improve Services to Individuals involved in the Criminal Justice System.
Arizona Mental Health Association Conference, Prescott, AZ.

2001 Supportive Housing for Individuals with Serious Mental Illness and Substance Abuse Disorders, Housing for the Homeless Conference, Phoenix, AZ.

2001 Crisis Intervention Training for the Phoenix Police Department, Phoenix, AZ.

2001 Integrated Treatment for Co-Occurring Disorders in a Rural Setting, National Rural Mental Health Association Conference, Wilmington, N.C.

2002 Best-Practice Guidelines for the Treatment of Co-Occurring Disorders, American Association of Community Psychiatrists Conference, Tucson, AZ.

2002 Court Ordered Treatment, Health Ed Resources, Phoenix, AZ.

2002 Arizona HIPAA Compliance, CMHS, AZ.

2002 Behavioral Health Services in Rural Communities, Arizona Rural Health Association, Prescott, AZ.

2002 Arizona Jail Diversion Programs, Innovations in Forensic Mental Health, New York University, New York, NY.

2002 Evaluation in the Real World, Arizona Substance Abuse Research Consortium, Sedona, AZ.

2002 A comparison of Supported and Independent Housing Programs, Housing for the Homeless Conference, Phoenix, AZ.

2002 Evaluating Behavioral Health Programs, National Conference of State Legislatures, AZ.

2002 Update on Arizona Behavioral Health Services, Mental Health Association Conference, AZ.

2003 Using a Logic Model to Determine Behavioral Health Network Sufficiency, DC.

2003 Developing an Integrated Mental Health and Substance Abuse Assessment, AZ.

2003 Benefits of Mental Health Courts, AZ.

2003 Evidence-Based Management of Schizophrenia, AZ.

2003 Justice Re-entry Strategies to Prevent Homelessness, AZ.

2004 Advancement in the treatment of Co-Occurring Disorders, National Institute on Drug Abuse Meeting, AZ.

2004 The Arizona Implementation of the New Freedom Commissions Report, Consumer Education Coalition, Tucson, AZ.

2004 Supported Housing: A Recovery Oriented and Cost-effective Alternative to Institutionalization. Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics, Washington, DC.

2004 Building a Recovery Oriented Behavioral Health System. Substance Abuse Summer Institute, University of Arizona.

2005 Developing Peer and Family Support in Arizona. Recovery Conference, Phoenix, Arizona.

2005 A Logic Model for analyzing Network Sufficiency, Summer Institute, Sedona, Arizona.

2005 Panel Discussion on Criminal Justice and Mental Illness, Phoenix, Arizona.

2005 Transforming Mental Health Systems into Recovery-Oriented Systems. Olmstead Coordinators Meeting. Washington, DC.

2005 Evidence-Based Practices and Recovery are Synergistic. Phoenix, Arizona.

2006 Got No-Shows. We have a Solution. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2006 Reducing No-Shows using a Client Directed Outcome Informed Approach. Southwest Training Institute. Tucson, Arizona.

2006 An analysis of Retention and Treatment Outcomes from Peer Support Services using the Client Directed Outcome Informed Treatment Approach. National State of the Knowledge Conference on Increasing Community Integration of Individuals with Psychiatric Disabilities. University of Pennsylvania Health System. Philadelphia, Pa.

2006 The Village Program: An Integrated Service Model. Statewide Conference on Homelessness, Arizona Coalition to End Homelessness. Phoenix, Arizona.

2006 Client Directed Outcome Informed Treatment. Statewide Conference on Homelessness, Arizona Coalition to End Homelessness. Phoenix, Arizona.

2006 A Behavioral, Phenomenological and Motivational Analysis of Why People Change and Why They Don't. Training Institute Lecture Series. Argosy University. Phoenix, Arizona.

2006 This Treatment isn't working. Could it be me? Mental Health Association Annual Conference. Phoenix, Arizona.

2006 Village approach to service delivery. Behavioral Health Community Forum. Phoenix, Arizona.

2007 Employment recovery services for people with behavioral health challenges. CARF Employment and Community Services International Conference. Tucson, Arizona.

2007 Client Directed Outcome Informed Treatment. United States Psychiatric Rehabilitation Association Annual Conference. Orlando, Florida.

2007 Adolescent Co-occurring Disorders and Effective Treatment Option. Family Centered Practice Conference. Phoenix, Arizona.

2007 Introduction to the Client Directed Outcome Informed Clinical Approach. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2007 Supervision of the Client Directed Outcome Informed Approach/Motivational Interviewing. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

2007 Introduction to the Client Directed Outcome Informed Clinical Approach. Southwest Training Institute. Tucson, Arizona.

2007 Supervision of the Client Directed Outcome Informed Approach/Motivational Interviewing. Southwest Training Institute. Tucson, Arizona.

2007 State and national Issues in Behavioral Health Services. Eric Gilbertson Advocacy Training Institute for Behavioral Health. Phoenix, Arizona.

2007 Use of Recovery Relationships: Demonstrating Effectiveness of Peer Supports. Arizona Coalition to End Homelessness. Phoenix, Arizona.

2008 Innovative Job Modifications for People with Long Term Mental Health Challenges in Recovery. CARF International Conference. Tucson, Arizona.

2008 A Person Centered Treatment Planning approach. Eric Gilbertson Advocacy Training Institute for Behavioral Health. Phoenix, Arizona.

2008 Cultural Competency: A Practical Method for Clinicians. 6th Annual Indian Health Services Conference on Behavioral Health/ Maternal Health. Phoenix, Arizona

2008 Benefits of the Child and Family Team Approach. 12th Annual Family Centered Practice Conference. Phoenix, Arizona.

2008 Translating What Works: Peer Support and Recovery. Heart and Soul of Change Conference. Phoenix, Arizona.

2008 Achieving Excellence in Supervision. Heart and Soul of Change Conference. Phoenix,, Arizona.

2008 Achieving Excellence in Your Setting. Heart and Soul of Change Conference. Phoenix, Arizona.

2008 Housing Services and Supports. Arizona Housing Summit. Phoenix, Arizona.

2008 Peer Support and Outcome-Informed Practices. Substance Abuse Summer Institute, Arizona State University. Sedona, Arizona.

CHAPTERS AND JOURNAL ARTICLES

2009 Transforming Public Behavioral Health Care: A Case Example of Consumer Directed Services, Recovery and Common Factors. With Robert Bohanske. In The Heart and Soul of Change, 2nd Edition: Delivering What Works in Therapy. Duncan, B., Miller, S., Wampold, B. and Hubble, M. American Psychological Association Press.

2008 Wellness and Recovery Employment Standards. With Randy Gray. Job Training and Placement Report. Volume 32, 9 , 1-3.

2007 Introduction to Child and Family Teams. With Bob Bohanske. Distributed by the Maricopa County Consumers, Advocacy and Providers Association.

2006 Arizona Behavioral Health Supervisory Training Series. With Bob Bohanske. Distributed by the Arizona Behavioral Health Providers Association.

2005 Housing Choice, Outcomes, and Neighborhood Characteristics in Seriously Mentally Ill/ Homeless Housing Programs: Analysis of a Phoenix Survey of SMI / Homeless Population with Alvin Mushkatel, Subhrajit Guhathakurta, and Jacqueline D. Thompson in International Journal of Public Administration

2004 An Analysis of Post-Booking Jail Diversion Programming for Persons with Co-Occurring Disorders. In **Behavioral Science and the Law** 22: 771-785. With Michael Shafer and Brian Arthur.

2002 Mental Illness and Substance Abuse: Making Matters Worse. In M. Berren (Ed.). **A Sourcebook for Families Coping with Mental Illness**. (pp 95-106), Mc Murray Publishing. With Christina Dye.

2001 Treating Offenders with Mental Disorders ad Co-Occurring Substance Abuse Disorders. In G. Landsberg and A, Smiley (Eds.) **Forensic Mental Health: Working with the Mentally Ill Offender**. Chapter 10 pp 1-21. With Christina Dye. Civic Research Institute.

2001 Jail Diversion in a Managed Care Environment: The Arizona Experience. In G. Landsberg and A, Smiley (Eds.). **Serving Mentally Ill Offenders** Chapter 8 pp 107-119. With Mike Shafer. Springer Publishing.

2001 Knowledge Transfer: Policymaking and Community Empowerment: **A Consensus Model Approach for Providing Public Mental Health and Substance Abuse Services**. With N. Broner, Christina Dye and William McAllister. Psychiatric Quarterly, Vol. 72 pp 79-102.

2001 Arizona's Integrated Treatment Initiative for the Dually Diagnosed. In **Community Mental Health Report**. Vol. 1 pp 21-27. Civic Research Institute. With Christina Dye.

2000 Collaboration: The Key to Successful Jail Diversion. **Proceedings from the Crime and Criminology in the Year 2000 Conference**. American Society of Criminology.

AWARDS

1990 Pennsylvania Department of Welfare Services Award

1997 Arizona Governor's Excellence Award for the development of a computerized Case File Review Tool.

1997 Arizona Governor's Excellence Award for the development and implementation of a Problem Resolution System.

2000 Arizona Governor's Excellence Award for initiating the Arizona Integrated Treatment Consensus Panel.

FEDERAL GRANT AWARDS

1995 Principal Investigator - Consumer Support Program - Funded by Substance Abuse Mental Health Services Administration.

1997 Principal Investigator - Housing Approached for Persons with a Serious Mental Illness - Funded by Substance Abuse Mental Health Service Administration.

1997 Principal Investigator - Jail Diversion for Persons with a Serious Mental Illness - Funded by Substance Abuse Mental Health Service Administration

1998 Co-Principal Investigator - Exemplary Practices Initiative - Integrated Substance Abuse Mental Health Treatment Models. - Funded by Substance Abuse Mental Health Service Administration.

1998 Principle Investigator - PATH Grant for Homeless Outreach - Funded by Substance Abuse Mental Health Services Administration.

2000 Principal Investigator – Project MATCH- Children's System of Care Initiative - Funded by Substance Abuse Mental Health Services Administration.

2001 Co-Principal Investigator – System Expansion Initiative for Treatment for Individuals with Co-Occurring Disorders- Funded by Substance Abuse Mental Health Services Administration.

2001 Project Coordinator – Olmstead Plan - National and State-Wide Coalition to Promote Community-Based Care.

2002 Co-Principle Investigator – Data Infrastructure Grant - Funded by Substance Abuse Mental Health Services Administration.

2004 Principle Investigator- State Infrastructure Grant for Children's Services – Funded by the Substance Abuse Mental Health Services Administration.

2005 Principle Investigator – Substance Abuse Services for Adolescents and Young Adults – Funded by the Substance Abuse Mental Health Services Administration.

2009 Project Director – Arizona project to assist individual's transition from Homeless to Independent Housing with Behavioral Health Services. – Funded by the Substance Abuse Mental Health Services Administration.