

1 **THIRD REPORT OF THE COURT MONITOR**
2 **ON PROGRESS TOWARD COMPLIANCE**
3 **WITH THE**
4 **AGREEMENT: U.S. v. STATE OF DELAWARE**

5 U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS
6

7 March 8, 2013
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9

10 **I. Introduction**

11 This is the third report of the Court Monitor (“Monitor”) on the implementation of the
12 above-referenced Settlement Agreement (“Agreement”) between the United States,
13 through the U.S. Department of Justice (“DOJ”), and the State of Delaware (“the State”).
14 This report roughly covers the six-month period July 15, 2012 through January 15, 2013.
15 The State has continued to make important ongoing progress in implementing many
16 elements of the Agreement since the Monitor’s last report in September, 2012. For this
17 reporting period, the Agreement specifies only one new benchmark to be achieved.
18 Accordingly, this mid-year report rates the State’s compliance with respect to that
19 provision and then provides comments on the State’s interim progress in some of the
20 Agreement’s other key areas. The next report, to be issued in the summer of 2013, will
21 discuss a large number of new benchmarks that are to be met by the two-year anniversary
22 of the Agreement.

23 As is summarized below, the State has been working diligently to not only meet the strict
24 language of the Agreement, but also to embed practices in its systems that embody the
25 spirit of the Americans with Disabilities Act (ADA) and the U.S. Supreme Court’s
26 *Olmstead* decision. This is no small feat. In Delaware (as elsewhere) many public
27 systems that are key to people with disabilities moving from the social sidelines to the
28 mainstream of their communities rely on practices that pre-date the ADA and that do not
29 necessarily prioritize the ADA’s goals. From the outset, the State’s approach to this
30 Agreement has been to examine and to realign processes within its Department of Health
31 and Social Services (DHSS), the Division of Substance Abuse and Mental Health
32 (DSAMH), and other public agencies to make ADA outcomes the natural work products
33 for the populations covered. Furthermore, while this Agreement relates specifically to
34 Delawareans who have Serious and Persistent Mental Illnesses (SPMI), the State is
35 appropriately considering how the reforms occurring on behalf of this population
36 translate to all of its citizens who are covered by the ADA. For all of the above reasons,
37 the progress that the State is making has required innovation and a capacity to critically

38 examine some longstanding practices. Not surprisingly, there have been—and, no doubt,
39 will continue to be—bumps in the road, some of which are noted in this report.
40 Furthermore, the broad scope and complexity of changes and new programs required by
41 the Agreement have meant that, on a practical level, every new challenge could not be
42 addressed at once. Nevertheless, the Monitor is pleased to report to the Court, to the
43 DOJ, and to the citizens of Delaware that the State is making admirable progress toward
44 meaningful compliance with the provisions of the Agreement. From the Governor’s
45 office, to the State agencies, and through various collaborations involving individuals
46 with SPMI, providers and other stakeholders, the Monitor has found widespread
47 dedication to fulfillment of the ADA for citizens with SPMI or other disabilities.

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50 **II. Ratings of Compliance with the Agreement**

51 Only one provision of the Agreement has a target date falling within the period covered
52 by this report:

53 III.G *Intensive Case Management*

- 54 I. *By July 1, 2012 the State will develop and begin to utilize 3 ICM*
55 *teams.*
56 II. *By January 1, 2013, the State will develop and begin to utilize 1*
57 *additional ICM team.*
58

59 **Substantial Compliance.**

60 The State has exceeded the requirements of this provision in that there are
61 currently 5 Intensive Care Management (ICM) teams statewide. These teams are
62 designed to serve individuals with SPMI who have significant needs, but who do
63 not require ongoing services on the level provided by Assertive Community
64 Treatment (ACT) programs. Because ICM is a new service that was launched
65 concurrently with new ACT teams and other community programs, it has taken
66 some time to sort through who can be most effectively served in what elements of
67 the evolving community service array. Partly as a consequence and partly as a
68 result of population density, in the southern parts of the state ICM teams are not
69 yet being fully utilized. DSAMH is working with providers to bring the use of
70 these programs to full scale. As of December, 2012, about 500 individuals were
71 receiving active intensive care management through these teams.

74 **III. Progress on Other Provisions of the Agreement**

75 The following discussion concerns provisions of the Agreement that do not have
76 benchmarks to be achieved during the period covered here and do not require new ratings
77 of compliance, but where there is work of particular significance to be reported. Unless
78 otherwise noted, the findings, ratings and recommendations from the Monitor's
79 September, 2012 report continue to apply to the State's efforts with respect to all
80 provisions of the Agreement, including those not discussed below.

81
82 **A. Data Systems**

83
84 Previous reports of the Monitor have noted that Delaware is hampered by very much
85 outmoded data systems, many of which operate in isolation from each other and which
86 capture data that are not timely. As a result, DSAMH has had to expend considerable
87 staff time in manually compiling basic information that is needed for routine quality
88 control and planning, and for reporting compliance with respect to many aspects of the
89 Agreement. A much needed comprehensive overhaul of the DHSS's electronic data
90 systems is underway; this should vastly improve the quality and timeliness of data both
91 within and across governmental divisions. It also entails initiation of electronic medical
92 records, which will dramatically improve access to information that is critical to service
93 provision and quality management.

94 The scope of this modernization effort is such that, realistically, a fully functional
95 integrated data system is years off. However, to address some of the key data
96 requirements that are immediate, the Monitor has been working with the State to devise
97 some interim work-arounds. The Target Priority Population List, discussed below, is one
98 such example.

99 Recommendation: The plans that are under way appear to be moving DHSS in the
100 direction of having a much more coherent and efficient flow of important information. It
101 is safe to say that the past 18 months of implementation of the Agreement have
102 reinforced an appreciation for analytic capacity within DSAMH, particularly the need for
103 an individual who is not only fluent with information technology, but also with the
104 complexities of service delivery systems affecting individuals with SPMI. Staff members
105 of DSAMH certainly are knowledgeable about mental health services and related
106 supports, but they have been working in an environment where today's information
107 technology has not been meaningfully embedded. Critical information is still being
108 conveyed in ways that don't lend themselves to aggregate analysis, such as through email
109 or fax. As an example, up until recently, determining whether or not individuals were
110 being discharged from DPC into integrated settings consistent with the Agreement
111 required tedious searching through paper hospital records, checking what type of housing

112 exists at specific street addresses, manually entering this information into a spreadsheet,
113 and then reformatting this information so it could be incorporated in the Target Priority
114 Population List (see below). That issue is now largely resolved, but the resolution is part
115 of a number of piecemeal fixes in response to a very broad array of routine data needs.
116 Fully integrating information technology in DSAMH’s operations and ensuring that the
117 Division derives maximal benefits for service delivery, cost effectiveness. and quality
118 oversight will require expertise that can drive a much needed change in culture and re-
119 education of the workforce. As the Monitor has noted in past reports, service delivery to
120 Delawareans with SPMI occurs within an incredibly complex service system.
121 Accordingly, both to address immediate needs and to ensure that the larger retooling of
122 DHSS’s data systems delivers to full advantage, it is very important that DSAMH have
123 the analytic expertise to integrate both the information and the service delivery elements.
124 The recommendations from earlier reports to bring the staffing capacity to DSAMH to
125 allow for such analytic expertise not only remain, but are strongly suggested for action in
126 the near future.

127

128 **B. Target Priority Population List**

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130 Section II.B of the Agreement requires the State to develop a Target Population List that
131 reflects several criteria placing individuals with SPMI at heightened risk of
132 institutionalization and other poor outcomes. These criteria include current or recent
133 psychiatric inpatient care through public programs, homelessness, emergency room use
134 related to mental health or substance abuse issues, and arrests or incarceration. At the
135 outset of the Agreement, Delaware’s mental health system was in a position typical of
136 state mental health departments nationwide with respect to data about these factors.
137 DSAMH had fairly good information about individuals being served at Delaware
138 Psychiatric Center (DPC) and people being served on an involuntary basis in the three
139 private psychiatric hospitals (Institutions for Mental Disease, or “IMDs”) with which it
140 contracts. But the Division had very limited information about people with SPMI—
141 including those individuals it already serves—who meet the Agreement’s criteria for
142 homelessness, emergency room use, or criminal justice involvement.

143 Such information is not only essential to ensure that individuals covered by the
144 Agreement are appropriately prioritized for services and supports, but is also critical to
145 planning public services. Furthermore, unaddressed issues among individuals with SPMI
146 result in avoidable public costs within mental health (e.g., preventable hospitalizations)
147 and other systems (e.g., emergency room use, police involvement, and incarceration). In
148 order to demonstrate the true social and fiscal impact of the reforms entailed in the
149 Agreement, the State needs good measures of how these various factors change over the
150 course of implementation.

151 During the past six months, the State has redoubled its efforts to establish a
 152 comprehensive and accurate Target Population Priority List (TPPL). This has required
 153 working across systems to capture data on homelessness, emergency room encounters,
 154 and criminal justice (through the Delaware Criminal Justice Information System, or
 155 “DELJIS”). The data are not yet entirely in sync. For instance, while DSAMH is able to
 156 get daily data about arrests of individuals who are already on the TPPL, it is still working
 157 to get information on current inmates within the correctional system who have SPMI and
 158 will be re-entering their communities. DSAMH’s information relating to emergency
 159 room use is based on Medicaid claims, which sometimes have time lags of several
 160 months. And data about psychiatric care in IMDs that is voluntary and is paid for
 161 through Medicaid is still cumbersome to retrieve on a timely basis.

162 Still, in a single spreadsheet, DSAMH now has information about over 7,000 individuals
 163 with SPMI who are prioritized for services under the Agreement. This represents about
 164 700 additional individuals since the last report, many of whom had been served through
 165 the state’s Medicaid or homeless services programs. Although the data will undoubtedly
 166 come to be further refined over time, a breakdown of the target population as of January
 167 31, 2013 already demonstrates the far-reaching implications the reforms required by the
 168 Agreement can have. In keeping with its provisions, the following is a breakdown of
 169 individuals on the TPPL (individuals may be represented in more than one category):

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171	Inpatient Care in DPC	9.2%
172	Inpatient Care in IMD	51.3%
173	Intensive Community Services (e.g. ACT).....	18.7%
174	Emergency Room use related to	
175	Mental Health or Substance Abuse Issues	27.9%
176	Homelessness	28.5%
177	Criminal Justice Involvement ¹	3.8%

178

179 The State is taking some noteworthy steps to better understand the factors that cause
 180 individuals to fall into these high-risk categories. For instance, DHSS has partnered with
 181 the State’s Department of Public Health and the University of Delaware to review
 182 emergency room utilization statewide by people with SPMI, whether primarily for

¹ Criminal Justice Involvement data are understated. The percentage shown reflects arrest data of people who are otherwise on the TPPL during a period beginning two years before the agreement plus 81 individuals who were treated on DPC’s forensic unit (Mitchell) during this same time frame. Not represented are individuals who were arrested or incarcerated, but not already appearing in at least one of the other categories. DHHS is working to resolve this issue.

183 physical health or for psychiatric issues. The goal is to discover factors that trigger
184 emergency room contact and, ultimately, to provide interventions that reduce that risk.
185 This project can yield invaluable information about breaking the cycle of crises that are
186 all too common disruptions in the lives of people with SPMI and, again, reflects the
187 State’s laudable efforts to secure meaningful systemic reforms.

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189 Recommendations:

- 190 1. DSAMH already has plans to utilize DELJIS arrest data to alert providers so that they
191 can intervene on behalf of individuals being served and, for Quality Improvement
192 purposes, to examine patterns of police encounters with people on the TPPL. For a
193 variety of reasons—among them the reality that arrests are the “front-door” for
194 incarcerations that are widespread among people with SPMI—it is recommended that
195 DSAMH quickly move forward with these plans. Ideally, every arrest of a person on
196 the TPPL should trigger a root-cause analysis to inform service refinements on
197 individual and aggregate levels.
- 198 2. As a part of the analytics referenced above in Section A, DSAMH should extract data
199 relating to hospitalization, emergency room use, homelessness and arrests in order to
200 identify trends attributable to the expanded array of community services and
201 improved procedures for pre-admission evaluations.

202
203 **C. Crisis Walk-In Centers**

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205 Section III.C of the Agreement required the State to establish a crisis walk-in center
206 serving the southern areas of Delaware by September 1, 2012, and this program was
207 launched just as the last Monitor’s report was issued. Since that time, the Ellendale
208 Recovery Resource Center (RRC) has become fully operational. The Monitor’s visit to
209 the program affirmed that RRC is not only designed to address a longstanding unmet
210 need in the southern part of the state, but that it is doing so with a model of service and in
211 a physical setting that are designed to reinforce individuals’ ability to recover. In contrast
212 to the often frenetic clinical environment of hospital emergency rooms, individuals
213 served at RRC find what is much more like a calm living room where they can talk to
214 trained staff and peers over a cup of coffee and, if desired, move to a private quiet space.
215 The program, which is operated through a contract with Recovery Innovations, is still
216 evolving within the local service system. As of this report, about 650 individuals in
217 mental health crisis have been seen at RRC since the program was initiated.

218 As a related matter, the Agreement requires training of law enforcement personnel about
219 the availability and purpose of crisis walk-in centers by July 1, 2013 (Section III.C.2).
220 Another requirement (Section III.D.2) has the same target date and also applies to all

221 provider staff; its goal is to reduce the use of hospital emergency departments. With
222 regard to both provisions, such training has been ongoing and is planned to continue so.
223 Furthermore, information relating to emergency room use that is now being routinely
224 collected for the Targeted Priority Population List (see Section B above) will allow the
225 State to generate trend data indicating whether reductions in emergency room use are
226 occurring as anticipated. Taken as a whole, the RRC, these training activities, and other
227 new initiatives (some of which are discussed in this report) are moving the system
228 towards significant improvements in how mental health crises are responded to within the
229 State.

230
231 **D. Civil Commitment**

232
233 Both of the past reports of the Monitor have noted the State’s extraordinarily high
234 reliance on court-ordered treatment for people with SPMI served in its public systems.
235 Court-ordered mental health treatment is properly used as an emergency measure, and it
236 should prompt individual and systemic analyses of how earlier voluntary interventions
237 might have averted the need (or perceived need) to turn to the courts. Over-reliance on
238 court-ordered treatment is generally a signal of problems in service, including problems
239 in accessing timely help or the use of legal coercion to offset staffing shortages that limit
240 consumer engagement.

241 Particularly in light of the community service enhancements that have occurred in
242 relation to this Agreement, neither of these issues should be at play at this point.
243 However, in the past several factors that are *non-clinical* have inadvertently encouraged
244 providers to involve the courts in mental health service delivery. These factors include a
245 policy whereby DSAMH would underwrite the cost of inpatient psychiatric care only
246 when it was provided on an involuntary basis, the convenience of using police to
247 transport individuals when they are under court order, practices whereby involuntary
248 treatment—particularly on an outpatient basis—would be sought and ordered in the
249 absence of specific criteria, and the apparent perception that hospital discharges of
250 individuals under continuing court orders shield providers from liability. As has been
251 discussed in the Monitor’s previous reports, all of these factors have contributed to a
252 climate that is in conflict with the ADA (and perhaps other laws) and that is inconsistent
253 with the recovery-oriented service system toward which the State is moving.

254 Delaware is making some important progress to promote less-restrictive services and to
255 reduce the unwarranted involvement of the courts in services for people with SPMI. As
256 was noted in the last Monitor’s report, enactment of House Bill 311 and House Joint
257 Resolution 17 were important accomplishment in that this legislation requires pre-
258 detention screening by a qualified mental health examiner, efforts to encourage voluntary
259 treatment (including payment for voluntary hospital care when warranted), and the
260 establishment of a study group to make recommendations about reforms in Delaware’s

261 overall mental health laws. Because House Bill 311 doesn't fully go into effect until
262 2014, the State has not yet realized all of its benefits. However, DSAMH is already
263 ramping up its programs for crisis intervention (e.g., mobile crisis services and the crisis
264 walk-in centers) in ways that will accommodate the upcoming legal requirements.
265 Furthermore, DSAMH is now reviewing for payment on case-by-case basis individuals
266 who meet civil commitment standards for hospitalization, but who are willing to be
267 admitted voluntarily.

268 Nevertheless, problems in court-ordered treatment persist in the State. For instance, the
269 Monitor has met with several mental health peers who recently observed the civil
270 commitment process on random days. They presented a consistent story of hearings that
271 last approximately five minutes, often relying on testimony from a doctor who has not
272 treated the individual, and where often the defense attorney concedes to whatever that
273 doctor recommends. On its face, if the individual, through his or her attorney, concedes
274 to what the doctor is recommending, one would expect that treatment would occur on a
275 voluntary basis. Yet, the peer advocates' observations are that virtually every case
276 culminates in an order for involuntary treatment order for hospital care, typically also
277 including court-ordered outpatient treatment. These reports are consistent with data on
278 the disposition of civil commitment cases maintained by DSAMH and regularly made
279 available to the Monitor.

280 In addition, peers who themselves have been subject to civil commitment in the State
281 report that they are not made aware of their rights or what was transpiring. They
282 indicated that in some instances, involuntary commitment occurred even though they had
283 indicated a willingness to accept treatment voluntarily, and that they were denied
284 opportunities for family members to be present at their hearings.

285 As has been noted in each of the Monitor's prior reports and is detailed in Attachment-1
286 to this report, Delaware remains very much an outlier among states in its use of outpatient
287 commitment. Based on the Monitor's analysis of data from December, 2012, there has
288 actually been a 28% *increase* in the number of individuals with outpatient commitment
289 orders, as compared with May, 2012. Furthermore, Delaware's neighboring states
290 (consistent with practices nationwide) use outpatient commitment only very rarely and
291 only with regard to individuals who have demonstrated histories of recurrent
292 hospitalizations and arrests despite intensive community supports. New York is a state
293 with a much-studied outpatient commitment program. The chart in Attachment-1 shows
294 that, adjusted for population, Delaware uses outpatient commitment at a rate that is over
295 *six* times higher than that of New York State, and even higher as compared to its
296 neighboring states.

297 In New York and elsewhere where it is used, outpatient commitment is a legal
298 intervention that is triggered by high rates of recidivism. Given its unusually widespread
299 use of such commitments, one might expect that readmissions to inpatient psychiatric

300 care are unusually high in the Delaware. In fact, they are not. Within the Delaware,
301 readmissions to psychiatric hospitals within 30 days of discharge actually occur at a rate
302 that is only 60% of the national average, and the State’s rate for 180-day readmissions is
303 only 61% of national norms.² If anything, then, the pool of individuals who seemingly
304 meet the customary criteria for outpatient commitment (high recidivism) would likely be
305 lower in Delaware than in most states, and if these criteria are carefully applied, relatively
306 small numbers of individuals would be considered. However, based on the Monitor’s
307 reviews of clinical and legal records of individuals placed under outpatient commitment,
308 orders continue to be issued based on extraordinarily vague facts. In addition, as has
309 been noted in the Monitor’s prior reports, often what the individual is required to do to
310 comply with an outpatient commitment order—other than to be “amenable” to
311 treatment—is not specified.

312 Pursuant to House Joint Resolution 17, there is a study group now examining the issue of
313 outpatient commitment. Furthermore, under current law, DSAMH is taking measures to
314 dramatically improve the consistency and specificity of information that is brought before
315 mental health commissioners when an outpatient commitment order is being sought. The
316 study group’s findings, as well as the impact of procedural changes that can be initiated
317 in the immediate term can inform the state legislature of broader mental health reforms
318 that might be taken up.

319 Recommendations: Based on all of the above, the Monitor again strongly recommends
320 actions contained in the September, 2012 report, including:

- 321 1. Production of monthly trending data relating to:
 - 322 a. Involuntary Hospitalizations,
 - 323 b. Voluntary Hospitalizations, and
 - 324 c. Outpatient Commitment Orders;
- 325 2. Immediate implementation of measures that can be taken within current law, such
326 as clearer formats and standards for seeking outpatient commitment orders, and
327 discussion of system improvements with providers and commissioners; and
- 328 3. Consideration by the study group of how further reforms in Delaware’s law can
329 solidify the gains that are now being made pursuant to the Agreement.

² Delaware’s 30-day readmission rate is 5.6%, compared with 9.3% nationally; the State’s 180-day readmission rate is 12.9%, compared with 21.0% nationally. U.S. Department of Health and Human Services, Center for Mental Health Services, Mental Health National Outcome Measures: 2011 Uniform Reporting System, <http://www.samhsa.gov/dataoutcomes/urs/2011/Delaware.pdf>

330 In addition, the Monitor now recommends:

- 331 4. Immediate measures to inform individuals of their rights when subject to court-
332 ordered treatment (whether inpatient and outpatient), including plain-language
333 written material and opportunities to have questions answered;
- 334 5. Measures that make civil commitment a more transparent process, such as
335 formalizing the role of peer advocates as court observers;
- 336 6. Consistent system-wide practices that encourage voluntary treatment when it is
337 needed either on an inpatient or outpatient basis; and
- 338 7. Promotion of instruments such as healthcare advance directives to allow substitute
339 decision-makers of an individual's choice—rather than the courts—to provide
340 needed assistance during periods of incapacity.

341

342 **E. Inpatient Psychiatric Care**

343

344 Section III.D.3 of the Agreement requires that within the next 17 months (by July 1,
345 2014) the State reduce patient days in publicly-funded psychiatric inpatient settings by
346 30%. This is achievable through a combination of mechanisms, including:

- 347 • The array of new community-based mental health services (such as Assertive
348 Community Treatment, Peer Supports, Mobile Crisis, and Crisis Apartments);
- 349 • New housing that can markedly reduce the vulnerabilities of people with SPMI,
350 including those who have been at heightened risk due to homelessness;
- 351 • Improvement in the State's substance abuse system (the inappropriate psychiatric
352 hospitalization of individuals who actually have acute substance abuse issues has
353 been a longstanding problem);
- 354 • The new Ellendale crisis walk-in center;
- 355 • Pre-admission screening (which is a part of new legislation enacted by the State);
356 and
- 357 • Improved Utilization Review.

358

359 The State has taken positive action on each of these components, but at this juncture they
360 remain in varying stages of implementation. Collectively, significant reductions in
361 inpatient use have not yet materialized, but based on the State's ongoing actions and if
362 the Recommendation that follows is acted upon, there is reason to expect that the
363 requirements for reduced inpatient use will be achieved. Comparing the most recent data
364 available (for the month of December, 2012) with the average for the baseline fiscal year
365 of 2010-11, total inpatient days are only about 3% lower today (4,834 vs. 4,710).
366 However, there has been a shift in where inpatient care is being provided. At the outset

367 of the Agreement, DPC accounted for 68% of the publicly funded inpatient days, and the
368 IMDs (private psychiatric hospitals) provided 32% of the days of care. As of December,
369 2012, DPC accounted for 63% of the inpatient days and the IMDs provided 37%.
370 Looked at in other terms, there has been a 9% reduction in the use of DPC and a similar
371 increase in the use of private settings, where Medicaid dollars sometimes offset the cost
372 of treatment.

373 There has also been a significant change in the length of stay at DPC. Reflecting a
374 concerted effort to provide the long-term care population at this hospital with appropriate
375 community alternatives (scattered-site supported housing among them), the State has
376 achieved a 28% reduction in the number of individuals with long-term stays at DPC since
377 the date the Agreement was signed. Thus, in addition to a reduction in the overall use of
378 DPC, there has been a notable shift in the type of care being provided, whereby today at
379 least half of the care being provided is short-term acute treatment.

380 Furthermore, the Monitor has engaged a consultant to work with the State to improve the
381 quality of nursing and direct care services provided at DPC and to further progress
382 towards recovery-oriented services. By all accounts, such consultation, which is planned
383 to continue during the coming six months, has proved invaluable in light of DPC's
384 reorientation towards acute care and several administrative changes recently instituted
385 within the facility.

386 Recommendation:

387 Measures that can reduce the State's reliance on inpatient psychiatric care, including
388 those listed above, continue to be challenged by the states' overly complex structure for
389 managing hospital care. As has been referenced in prior reports of the Monitor,
390 depending upon an individual's legal status and public payer source (i.e., Medicaid or
391 state mental health funds), hospital care may be overseen by DSAMH, a Medicaid
392 managed care entity, or both. And for a single individual, the payer and the responsibility
393 for oversight may shift from hospital admission to hospital admission within a single
394 year. This service structure is not only challenging for individuals who are receiving
395 publicly funded mental health services, but it undermines accountability for the
396 management of inpatient care in the IMDs to the point that oversight is piecemeal, at
397 best. Taken together with the concerns about basic legal protections, discussed above,
398 there is an urgent need to for the State to initiate meaningful controls over hospital use.
399 While a number of management models could prove effective, it is strongly
400 recommended that the State establish a single—and unshifting—point of accountability
401 for oversight, monitoring, and maintenance of information relating to psychiatric
402 hospitalizations on individual and aggregate levels. Establishing such accountability is
403 critical to the State if it is to meet the requirement of the Agreement that inpatient days be
404 reduced by 30% by July 1, 2014.

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F. Mobile Crisis Teams

Section III.B of the Agreement requires the State to develop statewide mobile crisis services. The September, 2012 Monitor’s report noted that while the state was making progress in extending mobile crisis services to the southern counties, it was encountering difficulties in filling positions and bringing this program to scale in all areas. Obviously, mobile crisis services are pivotally important, both as an emergency response and to ensure that individuals are afforded interventions in the least restrictive manner appropriate. In many instances, mobile crisis services can divert individuals from hospital care when crisis apartments or some other community-based intervention can serve as alternatives. The nature of mobile crisis work requires specialized, carefully trained staff and it often presents challenges in terms of recruitment and retention. Problems in maintaining full staffing of mobile crisis have persisted during the six-month period of this report. Notwithstanding staffing issues, recent data show that the State has been able to meet the one-hour face-to-face response time required by the Agreement for 95% of the referrals received. As mobile crisis becomes more integrated into the service system statewide, the demand for this service will certainly increase, thereby intensifying the need for full and stable staffing.

Recommendation: Because of the unique and critical role of Mobile Crisis services, it is critical that the State address factors that challenge the recruitment and retention of an effective workforce, including a compensation package that is commensurate with the specific nature of this work.

G. Transition Planning

Section IV of the Agreement requires the State to establish *Olmstead*-compliant transition planning for individuals treated in DPC or one of the IMDs. Among the requirements are: an assessment process beginning with the presumption that an individual can live in an integrated community setting if sufficient supports are offered, timely involvement of a responsible community provider in discharge planning, and processes to ensure that individuals are not placed into less-than-integrated settings without appropriate review. As was noted in the Monitor’s last report, these measures have been successfully implemented at DPC, both for individuals receiving long-term care services and for those receiving short-term acute care. Extension of these processes to the IMDs has been slower and less consistent, complicated in part by the dual responsibilities of DSAMH and Medicaid’s managed care entities in those settings. Recently, DSAMH has taken some positive steps to assure that individuals over whose care it has direct oversight are afforded appropriate assessments for integrated community services (including housing)

445 and engagement by community service providers. These measures are consistent with
446 recommendations made in the Monitor’s September, 2012 report. The development of
447 processes to address the needs of individuals whose inpatient care is managed by
448 Medicaid, including the care coordination provided by that system, has proceeded much
449 more slowly. Meetings to discuss this issue with leadership from the State’s Division of
450 Medicaid and Medical Assistance are scheduled in the near future.

451
452 Recommendation: The State should move quickly to ensure that the requirements of the
453 Agreement relating to Transition Planning are extended to all individuals with SPMI who
454 are admitted to an IMD under publicly funded programs, including Medicaid. Thus far,
455 this has not occurred.

456

457 **H. Substance Abuse**

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459 A substantial population of individuals with SPMI and co-occurring substance abuse is
460 covered by the Agreement. Furthermore, as has been noted in previous reports of the
461 Monitor, individuals who have primarily substance abuse disorders (sometime without
462 evident mental illnesses) have tended to drift into psychiatric hospitals because
463 appropriate alternatives are often difficult to access. When this occurs (and the Monitor’s
464 first report suggested that such admissions are not infrequent), resources that are intended
465 for mental healthcare are diverted. For these reasons, and because DSAMH has authority
466 over both mental health and substance abuse services in the state, the availability of
467 appropriate community based substance abuse services affects the State’s compliance
468 with the Agreement. DSAMH recently engaged a consultant to evaluate the capacity and
469 structure of the state’s substance abuse system, and the Monitor has met with the
470 consultant to discuss the impact of his findings and the potential for better integrating
471 substance abuse and mental health services. Furthermore, the State’s recently expanded
472 capacity to conduct reviews of hospital admissions at DPC and the IMDs should provide
473 further information about the trajectory leading to the psychiatric hospitalization of
474 individuals whose immediate problems primarily relate to substance abuse. In the past,
475 the Monitor has recommended that hospital staff play an active role in flagging cases
476 where psychiatric inpatient admissions are found to be attributable to substance abuse.
477 Such a process would further facilitate DSAMH gaining an understanding of the scope of
478 unaddressed substance abuse issues and meaningful remedies.

479 Recommendation: The Monitor strongly suggests that DSAMH continue to utilize its
480 national consultant to assist in the reorganization of substance abuse services, including
481 factors that place individuals with substance abuse problems and those with co-occurring
482 disorders at heightened risk of institutionalization.

483

484 **I. Impact of Delaware’s *Olmstead* Reforms**

485 The Agreement delineates numerous quantitative benchmarks—some of which are
486 discussed above—to be met in the implementation process. These benchmarks are
487 important to ensure that there is a common understanding of some of the key actions the
488 State will take and how these actions will unfold over the five-year period covered.
489 Furthermore, they are consistent with the State’s efforts to ensure quality in services and
490 to prudently manage its resources through data-driven decision making.

491 A critically important goal embedded in the Agreement is that “people with SPMI can
492 live like the rest of Delawareans” (Section II.E.1.a). This goal reflects the essence of the
493 ADA, yet is not easily captured in numeric data or even by the existence of a new
494 program. For this reason, in addition to reviewing data, the Monitor spends a good deal
495 of time interacting with stakeholders to get a sense of the on-the-ground meaning of the
496 recent improvements in services. These interactions regularly include parties who are
497 positioned to see what is actually occurring: individual consumers of public mental health
498 services; representatives of the vibrant and insightful peer movement that has taken hold
499 in the State; advocates including NAMI, the Mental Health Association; individual
500 providers; and provider associations such as DelARF (the Delaware Association of
501 Rehabilitation Facilities). If the opinions of these diverse stakeholders over the 18 months
502 of implementation can be encapsulated, it would be that skepticism based on a history of
503 broken promises is giving way to a sense of optimism. Certainly, the transition process
504 continues to present some real challenges, but there is an increasingly unified view that
505 things are heading in a good direction, and a sense of pride at what has been
506 accomplished thus far.

507 Two elements have garnered particular enthusiasm: the development of integrated
508 supported housing options that allow individuals with SPMI to live in ordinary settings,
509 and the State’s efforts to assist individuals in obtaining mainstream employment. In
510 contrast to the important benchmarks reflecting the development of a new service (e.g.,
511 the number of ICM teams), in a very real sense, stable mainstream housing and
512 employment are the fruits of the State’s new service array. Thus, while Delaware is
513 meeting—and in some instances surpassing—most of the numeric targets of the
514 Agreement, its accomplishments with respect to these two factors demonstrate that it is
515 also succeeding in the more qualitative goals of the ADA.

516

517 **J. Integrated Supported Housing**

518

519 One key provision of the Agreement (Section III.I) requires the creation of new scattered-
520 site supported housing for people with SPMI. By July 1, 2013, the State is required to
521 support a total of 450 individuals in integrated housing. This includes 150 individuals in
522 pre-existing supervised apartments that are grandfathered into this requirement.

523 Accordingly, the State is required to provide an additional 300 individuals housing
524 vouchers, subsidies, and bridge funding in fully integrated scattered-site housing to meet
525 the July 1, 2013 benchmark.

526 The State appears well positioned to more than meet the upcoming benchmark relating to
527 housing. Between housing funded through various HUD programs, Delaware's State
528 Rental Assistance Program (SRAP), DSAMH funds, and housing costs that are covered
529 by its new Community Reintegration Support Program (CRISP), the State expects to
530 provide scattered-site supported housing to at least 444 individuals by July 1, 2013.
531 Added to the 150 individuals who are living in pre-existing semi-integrated housing, a
532 total of 594 individuals will be supported. This far exceeds the target of 450 individuals
533 for this year and is a testament to the State's earnest efforts with regard to this key
534 indicator of integration.

535 The Monitor's random visits with individuals living in supported housing developed
536 pursuant to the Agreement confirm that they are truly integrated—that is, they are
537 residing in ordinary apartment complexes interspersed with people who do not have
538 disabilities. The supportive services that are being provided reflect movement within the
539 system toward an orientation that promotes recovery. These individuals proudly point to
540 how they have personalized their apartments; several, for the first time in decades, are
541 now living in what they rightly call homes of their own.

542 Aggregate data from the State show that the Agreement is having the intended effect of
543 rebalancing the housing available to people with SPMI so that they have real choice in
544 terms of where they live. At the outset of the agreement, only 7% of the housing
545 generally available to this population was fully integrated (as defined in the Agreement);
546 the remainder was in congregate settings or settings where people with disabilities were
547 clustered in a single building. By the end of July of 2013, 32% of the housing available
548 to people with SPMI through this Agreement is expected to be in fully integrated settings.
549 The State is doing an impressive job in not only expanding new integrated housing
550 opportunities for individuals with SPMI, but in ensuring that this housing meets the
551 standards of the Agreement. And, as is referenced above, the State's achievements in this
552 regard are notable not only because where one lives is an essential indicator of ADA
553 compliance, but also because this success reflects the convergence of other services and
554 supports contained in the Agreement.

555

556 **K. Supported Employment**

557

558 Governor Jack Markell, both in his Delaware role and as Chair of the National
559 Governor's Association, has launched initiatives to promote the employment of people
560 with disabilities. Employment, like integrated housing, is an important indicator of
561 whether the goals of the ADA are being meaningfully achieved, and this is particularly so

562 for adults with SPMI. Nationwide, people with SPMI have extraordinarily high levels of
563 unemployment, even prior to today's economy where employment is a challenge for
564 individuals whether or not they have disabilities.

565
566 Since the last report, the Monitor has had an opportunity to meet with the leadership of
567 the State's Division of Vocational Rehabilitation (DVR), which has a close and
568 productive working relationship with DSAMH. The value of this relationship is
569 evidenced in recent data showing that the State is far exceeding the requirements of the
570 Agreement. Under Section III.J of the Agreement, the State was slated to provide
571 supportive employment to 100 individuals per year by July 1, 2012 and to an additional
572 300 individuals per year by July 1, 2013. As of January, 2013, a total of 1,049
573 individuals with SPMI have received active supported employment services (for instance,
574 job preparation and training) since the Agreement was signed, and of these people, 206
575 were employed in mainstream work settings. This is a very important and commendable
576 achievement.

577
578 Recommendation: In consultation with DVR and DSAMH, it is evident that further gains
579 in the employment of people with SPMI can be realized if an expectation of work is
580 better embedded in the service orientation of providers. Building on lessons learned from
581 the State's effective (and ongoing) efforts to prompt a culture change relating to
582 supported housing, meetings with DVR have suggested that a similar path might be taken
583 with respect to supported employment. In the coming months, the Monitor is planning a
584 series of additional meetings with DSAMH and DVR to chart out a course towards an
585 "employment first" model.

586
587
588

589 **III. Summary**

590
591 During the past six months, the State has continued to make significant progress towards
592 fulfillment of the Agreement on behalf of individuals with SPMI. Since the Agreement
593 was executed about 18 months ago, the State has restructured its mental health service
594 system and launched an array of new programs to allow individuals to participate in the
595 mainstream of their communities, living in ordinary housing with supportive services
596 and—slowly, but increasingly—entering in the workforce. At the same time, the State
597 has dramatically shifted away from relying on hospitals to provide long term psychiatric
598 care; the bulk of publicly funded psychiatric hospitalization is now for short-term acute
599 services and most people who had been on DPC's long-term care units are now living in
600 far more integrated community settings. Because this report is being issued at a time
601 when only one new benchmark was slated to be reached under the Agreement (the State

602 was found to be in substantial compliance with this benchmark relating to Intensive Case
603 Management), this report focuses on provisions of the Agreement where the State is
604 making particularly notable progress (for instance, with regard to integrated housing and
605 supported employment) and on some areas where it is working to overcome some
606 longstanding challenges (for instance, around its data systems and the over-reliance on
607 court-ordered treatment). Assuming that the State maintains its efforts and appropriately
608 addresses structural issues such as those discussed in this report, it is well positioned to
609 meet the requirements of the Agreement during the coming years. The Monitor
610 commends the continuing commitment of the leadership of the State to the ADA, on
611 which the Agreement is substantially based, as well as the State's solid achievements
612 over six months covered by this report.

613

614 Respectfully Submitted,

A handwritten signature in cursive script that reads "Robert Bernstein". The signature is written in black ink and is positioned to the right of the typed name below it.

615

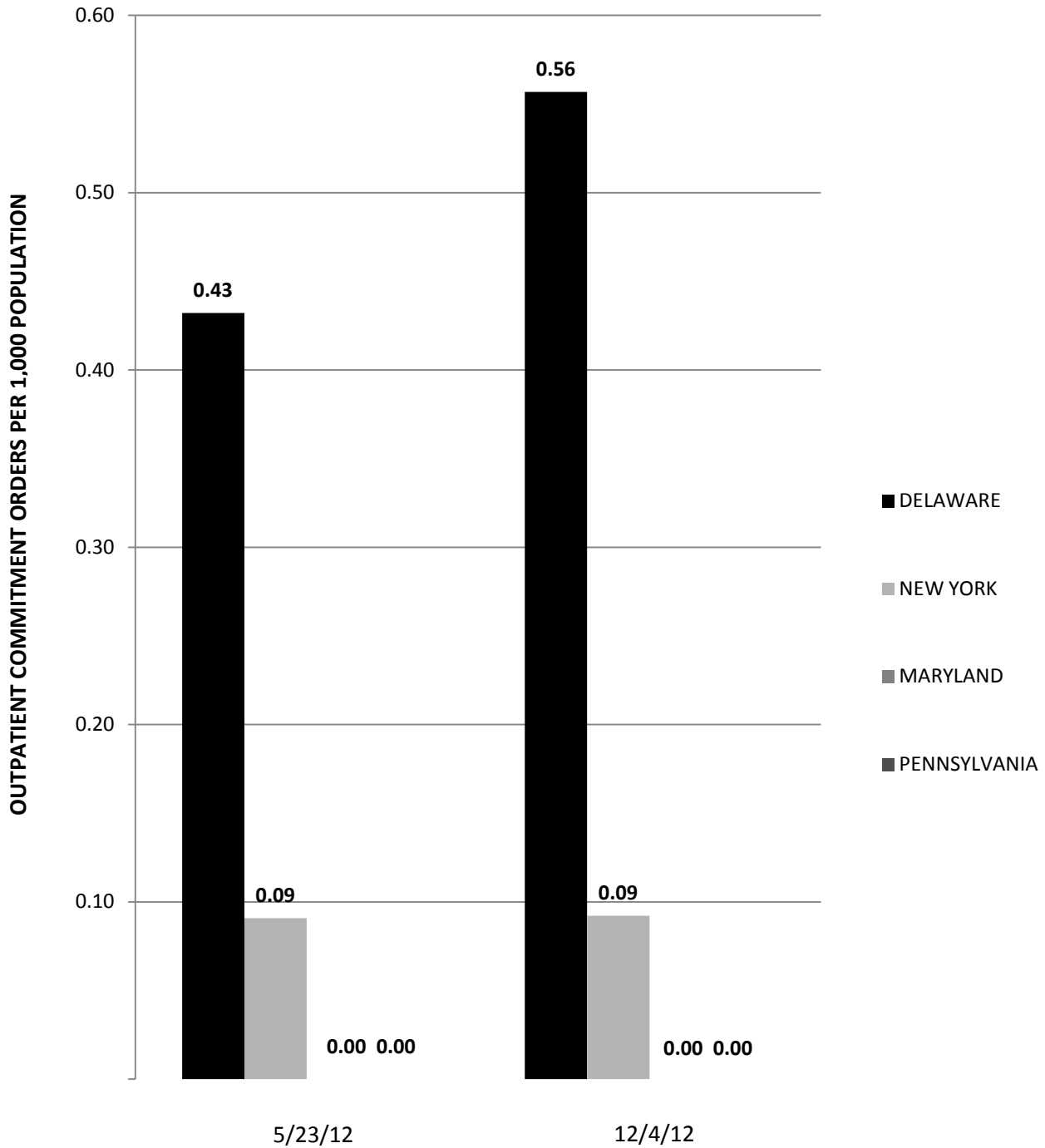
616 Robert Bernstein, Ph.D.

617 Court Monitor

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Attachment 1

**Comparison of Delaware, New York, Pennsylvania & Maryland
PER CAPITA NUMBER OF INDIVIDUALS
WITH ACTIVE OUTPATIENT COMMITMENT ORDERS
May & December, 2012**



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625