## Second Progress Report on

# Implementation of the Settlement Agreement

### Between the U.S. Department of Justice and the State of Delaware

**December 15, 2013**


**DELAWARE HEALTH AND SOCIAL SERVICES**

**Division of Substance Abuse and Mental Health**

1901 North DuPont Highway, New Castle, Delaware 19720

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Dear Citizens of Delaware,

In the second year of implementation of the Settlement Agreement between the U.S. Department of Justice (USDOJ) and the State of Delaware, we are pleased to report that the State has made significant progress in reforming the mental health system and in meeting the benchmarks established in the five-year agreement signed July 6, 2011. We continue our efforts to build an improved behavioral health system that will meet the desires of individuals—our neighbors, friends and family members—to live ordinary lives with identified services and supports. We have made significant progress; however, there remain challenges to overcome in our State's pursuit of excellence in behavioral health service provision.

For Delaware, the Settlement Agreement is the blueprint to ensure that the State complies with the Americans with Disabilities Act and carries out the integration mandate in the Olmstead ruling. We have welcomed the challenges it sets forth and continue to see this mandate as an opportunity and a benefit to Delawareans. To us, it is about providing services for a better and stronger Delaware.

The robust community system we envision focuses on a recovery-based, trauma-informed system of care that can achieve better outcomes for persons living with mental illness. We are building a system that serves individuals who have persistent mental health issues so they can live in the home of their choosing, have meaningful employment and participate and thrive as members of our communities. As this report demonstrates, the Division of Substance Abuse and Mental Health (DSAMH) continues to create and enhance community-based mental health programs. The Delaware Psychiatric Center (DPC) continues to transform to an acute mental health hospital for stabilization—just as a general hospital would be for individuals with a physical health crisis. DSAMH also has expanded the availability of crisis stabilization beds throughout the state in typical apartment settings, expanded peer-to-peer counseling and continued to pursue affordable housing and supportive services to allow clients to live safely and independently in the community. The reform of Delaware's emergency mental health detainment law provided for credentialed mental health screeners who work closely with emergency doctors, psychiatrists and others to conduct emergency evaluations of individuals, preventing unnecessary encounters with law enforcement and avoiding needless trips to emergency rooms and psychiatric hospitals. There are now 139 Delaware Mental Health Screeners who received their credential after completing 40 hours of training. Along with 142 Emergency Room physicians (who also received specialized instruction) and 12 psychiatrists, these experts in community-based treatment options are successfully diverting individuals in crisis to the most appropriate, least restrictive level of care. This is only our first step in bringing Delaware's mental health statutes into the 21st Century. The House Joint Resolution 17 Study Group continues its work reviewing all of Delaware's mental health laws and procedures with a final report on its recommended changes forthcoming in 2014.

The second year of the Settlement Agreement has seen our continued progress in reforming Delaware's behavioral health system of care. We extend our appreciation to all of the consumers, families, advocates and stakeholders who play such an important and valuable role in assuring the excellence of reforms. We will look forward to your ongoing guidance in the year to come.

We encourage you to contact us with questions, concerns or comments.

Sincerely,

***Rita Landgraf***
Cabinet Secretary
***Delaware Department of Health and Social Services***

***Kevin Ann Huckshorn***
Director
***Division of Substance Abuse and Mental Health***

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## OVERVIEW

From November 2007 to November 2010, the U.S. Department of Justice (USDOJ) conducted a three-year investigation of the Delaware Psychiatric Center. The investigation culminated in a letter to the State, dated November 9, 2010, citing the USDOJ findings. Based on the findings, the State of Delaware was sued by the USDOJ because of the lack of compliance with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead decision. The USDOJ and the State of Delaware negotiated a settlement and signed the Settlement Agreement in July 2011.

The Settlement Agreement is broken down into the following areas:

- Section II: Substantive Provisions - defines the parameters and services which need to be implemented
- Section III: Implementation Timeline - identifies and quantifies substantive provisions in the form of the targets by due date
- Section IV: Transition Planning – describes the process for transition from current situation to implementation of substantive provisions
- Section V: Quality Assurance and Performance Improvement – describes how and what quality assurance and performance improvement shall include and instructs on annual reporting
- Section VI: Monitor and Monitoring – identifies the Court Monitor and his responsibilities
- Section VII: Construction and Termination - establishes the end date of the Settlement Agreement assuming the targets are met and other provisions of termination
- Section VIII: General Provisions – defines who is responsible to the provisions of the Settlement Agreement
- Section IX: Implementation of Agreement

In Section V. Quality Assurance and Performance Improvement F. Reporting, Page 19 the Settlement Agreement addresses the requirement that the State publish an annual report as follows:

"The State will publish an annual report identifying:

- The number of people served in each type of service described in the agreement;
- Unmet needs using data gathered during admission assessments, discharge planning process and community provider reports, and
- The quality of services provided by the State and the community providers using data collected through the risk management system, the contracting process, and the Quality Service Reviews."

This is the Second Annual Report issued by the Department of Health and Social Services (DHSS) on behalf of the State of Delaware. The first report was issued in May 2013, covering the first eighteen months of the Settlement Agreement.

The first annual report was based on the first three Court Monitor Reports dated: January 20, 2012, September 5, 2012, and March 8, 2013.

This report is largely based on the third and fourth report issued by the Court Monitor dated March 8, 2013, and September 24, 2013, and the overall accomplishments in year two of the Settlement Agreement. Per Section VI Monitor and Monitoring of the Settlement Agreement the USDOJ appointed a Court Monitor to oversee the implementation. The Court Monitor is required to produce a report every six month on the progress of the State meeting the targets as outlined in the Settlement Agreement.

There have been a number of successes achieved throughout the two years of the Settlement Agreement. In general the State has met the targets that were established by the USDOJ. The challenges for the State have included developing a solid new infrastructure of the mental health system that will support long term changes. To assure significant changes, the Division of Substance Abuse and Mental Health (DSAMH) has had to reorganize the public state mental health system and implement new practices and processes. DSAMH, a Division within the Department of Health and Social Services (DHSS) the single state agency responsible for the day-to-day management of the public adult mental health and substance use disorder programs for the State.

This report addresses:

- Section I – Accomplishments;
- Section II – Recommendations from the Court Monitor and the Challenges to Implement the Recommendations, and
- Appendix: Status of the Settlement Agreement Targets for FY13.

## SECTION I – ACCOMPLISHMENTS

To meet the Targets (see Appendix: Status of the Settlement Agreement Targets for FY13) of the Settlement Agreement and to ensure the changes in the mental health system are long lasting, DSAMH had to look at the core issues that were driving system delivery in 2009. DSAMH had to go beyond creating a community service system that just met the Targets of the Settlement Agreement to revamp the infrastructure so that the system changes were supported by DSAMH-documented expectations in contract provisions, in standards for licensure, and in the monitoring of those provisions and standards. DSAMH had to ensure that these changes would be embedded in the system far beyond the duration of the Settlement Agreement.

The core issues range in scope and include but are not limited to:

- ***Civil laws*** concerning how a person with a mental health disability would be treated by the justice system;
- ***Data concerns*** (discussed more in Section II – Recommendations and Challenges) that covered the entire spectrum of "data" from its collection and management, to analytics, forecasting and staffing to accomplish data-related tasks;
- ***Delivery of actual services***, such as crisis intervention, which included the time it takes for a mobile crisis team to respond to a crisis call;
- ***Housing supports***, including developing relationships with landlords to ensure the integrated housing was a success from an access standpoint and unbundling housing from client services;
- ***Delivery of supportive employment***, services, including structuring payments to service providers for providing supportive employment to clients and partnering with the Delaware State Department of Labor and Division of Vocational Rehabilitation (DVR) on staffing and service delivery;
- ***Enhancing Peer Support Services***, including developing a strong Peer Movement in the State, and
- ***Intra- and Inter-Department coordination***, entailing more consistent dialogue and shared partnerships with the divisions within the Department of Health and Social Services (DHSS), specifically coordinating with the Division of Medicaid and Medical Assistance (DMMA) on Medicaid reimbursements for service providers and managing the services of Medicaid funded clients who have Serious and Persistent Mental Illness (SPMI), are funded by Medicaid and managed by the Managed Care Organizations (MCOs), as well as partnering with State agencies not under the DHSS umbrella such as the Delaware State Housing Authority.

DSAMH has addressed and continues to enhance the community-based service delivery system by implementing Assertive Community Treatment (ACT) teams, Intensive Case Management (ICM) teams and Targeted Care Management (TCM) teams. Additional integrated housing and supportive employment are being provided to the clients according to the philosophy and provisions of the Americans with Disabilities Act (ADA) and the Olmstead Decision. (See the Appendix: Status of the Settlement Agreement Targets for FY13)

Many of the accomplishments reflect the hours of work by a variety of stakeholders. The following accomplishments were presented to a representative from the USDOJ and the Court Monitor in July 2013 as a review of the FY13 implementation of the Settlement Agreement.

### Changing the Legal Structure

In FY12 the State Legislature passed House Bill 311 and House Joint Resolution 17. House Bill 311 is also discussed in Section II: "Recommendations from the Court Monitor and the Challenges to Implement the Recommendations." This legislation revised the way persons in crisis with a suspected mental illness are evaluated with the aim of preventing unnecessary inpatient hospitalization and improving the process through which evaluations occur.

The law took effect when signed in July 2012. It was written to allow a one-year implementation

period where the old system would continue so there were no gaps while the new system was being built and implemented. Before HB 311 became law, any person could have someone taken into custody by law enforcement because they said someone posed a risk to themselves or others. With the changed law came more resources; people can be evaluated anywhere in the State and law enforcement do not need to become involved. Another important change is regarding detention for an evaluation. Prior to HB 311 becoming law, any Delaware licensed physician could have a person held for an involuntary 24-hour mental health evaluation. As a result of the change, only psychiatrists and credentialed mental health screeners can have a person held for an involuntary 24-hour mental health evaluation. The law required DSAMH to establish the criteria and process for credentialing, which it has successfully deployed. The credentialing process includes training, testing and placement of Credentialed Mental Health Screeners throughout the state.

### *Certification of Credentialed Mental Health Screeners*

**Issue:** Standardization for Mental Health Screeners

As explained above, prior to July 1, 2013, anyone in Delaware could petition for an individual to be held on a 24-Hour Emergency Detention to determine the need for psychiatric hospitalization. There were a high number of clients with suspected mental health conditions in Emergency Rooms, non-mental health professionals requesting psychiatric detentions, and as result, a high number of unnecessary psychiatric hospitalizations.

**Background:** The Legislature recognized the need to change the 24-hour detention process and created Credentialed Mental Health Screeners, permitting only individuals who are certified screeners to initiate a 24-hour detention for psychiatric assessment. Law enforcement personnel may be involved if safety is a concern, but only a Credentialed Mental Health Screener can decide a person must be held involuntarily for a 24-hour evaluation.

Delaware-licensed psychiatrists are automatically Credentialed Mental Health Screeners. Psychiatrists and Board-Certified Emergency Room physicians are required to review a packet of training materials related to the process. Other professionals may become Credentialed Mental Health Screeners pursuant to regulations promulgated by DSAMH. Delaware-licensed physicians (who are not Board Certified in Psychiatry or Emergency Medicine) are required to complete a four-hour block of instruction, while licensed mental health professionals and unlicensed mental health professionals who work under the direct supervision of a psychiatrist complete a week-long training. Pursuant to the regulations, mental health professionals with a Bachelor's Degree or above and Registered Nurses must complete a 40-hour training course and pass an examination to be certified as a screener.

**Final Outcome:** Two 40-hour screener trainings and two (2) four-hour emergency room physician trainings were held in May and June of 2013. The State's two Mobile Crisis Intervention teams had a sizable number of staff trained and there was also representation from the state's community mental health centers, local psychiatric hospitals and community providers. Nearly 200 Mental Health Screeners are available to serve the state's Emergency Rooms and designated psychiatric facilities and Mobile Crisis Teams, including 139 Credentialed Mental Health Screeners, as well as 12 psychiatrists and 142 emergency room-based physicians. Mental Health Screeners will assess individuals over 18 years of age and determine whether or not to recommend 24-hour detention or refer to the least restrictive community-based care.

It is anticipated that the screening process will help to alleviate trips to Emergency Departments by persons experiencing symptoms of psychiatric illness. Screeners are expected to have a more thorough understanding of the concept of dangerousness to self or others and to be more knowledgeable about community-based care interventions that can prevent individuals from being hospitalized unnecessarily.

House Joint Resolution 17 was also passed by the State Legislature in FY12. The Resolution created a Study Group tasked to conduct a comprehensive evaluation of Delaware's civil mental health laws, including involuntary commitment, and to make recommendations regarding improving those laws by January 2014. Service Providers in Delaware have made great strides to reduce involuntary commitment while the HJR 17 Study Group researched the issues and recommended improved ways to work with persons who are in need of mental health treatment, including those who enter the system through the civil involuntary commitment process. (*see* Figure 1: New and Dismissed Involuntary Commitments SFY13, page 11) Below is an explanation of the work of the State-Appointed Committee, DSAMH and the Attorney General's staff.

### *Involuntary Civil Commitment: HJR 17 Committees Measurements*

**Issue:** Overuse of outpatient commitment.

Involuntary civil commitment is a legal procedure whereby individuals posing a threat to themselves and/or others are involuntarily held at an inpatient facility against their will. Following the inpatient stay, clients have most often been placed on "outpatient commitment." This has been the standard process in Delaware for many years.

**Background:** Though Delaware law does not specifically provide for outpatient commitment, the "convalescent" category (language in current statute) of clients has been used to place clients in that status once they leave the inpatient facility. Under the old model of psychiatric care in Delaware, it was essential for clients to be monitored by the court to ensure continued participation in medication and treatment. There were simply too few resources within the community to ensure the public and personal safety associated with such compliance. In recent years, Delaware's reform effort has led to the creation of an array of resources in the community serving individuals with serious persistent mental illness. Therefore, the number of individuals on outpatient commitment should decline and eventually be drastically reduced.

Since the laws in Delaware do not currently reflect the actual changes taking place in the mental health field, DSAMH will support the HJR 17 Study Group's proposed changes to Delaware Law when they are introduced in the General Assembly. It is also necessary to change the mind-set of those involved with involuntary civil commitment. For instance, it has been standard operating procedure for doctors from inpatient facilities to request from the court "inpatient commitment followed by outpatient commitment" in nearly all cases brought to mental health court. It has also been standard for the court to approve a very large majority of those requests. Subsequently, many individuals were kept on outpatient commitment for a number of years--in some cases, well over a decade.

To date, professionals participating in the mental health courts have felt compelled to ensure compliance with treatment through outpatient commitment. This has been due to the lack of the necessary array of community-based resources, and was seen as an effort to protect the public and the consumers. However, in many cases, outpatient commitment is frequently ineffective, intrusive and time-consuming. Many consumers under outpatient commitment orders were readmitted to inpatient facilities. This fact demonstrates that these consumers did not feel obligated to adhere to treatment simply because they were subject to commitment orders.

Individuals who have been on commitment for more than five months are currently required to attend hearings every six months. This biannual schedule does not truly encourage daily participation in treatment. Additionally, a failure to appear for treatment and/or court hearings causes the mental health court to issue a Capias for

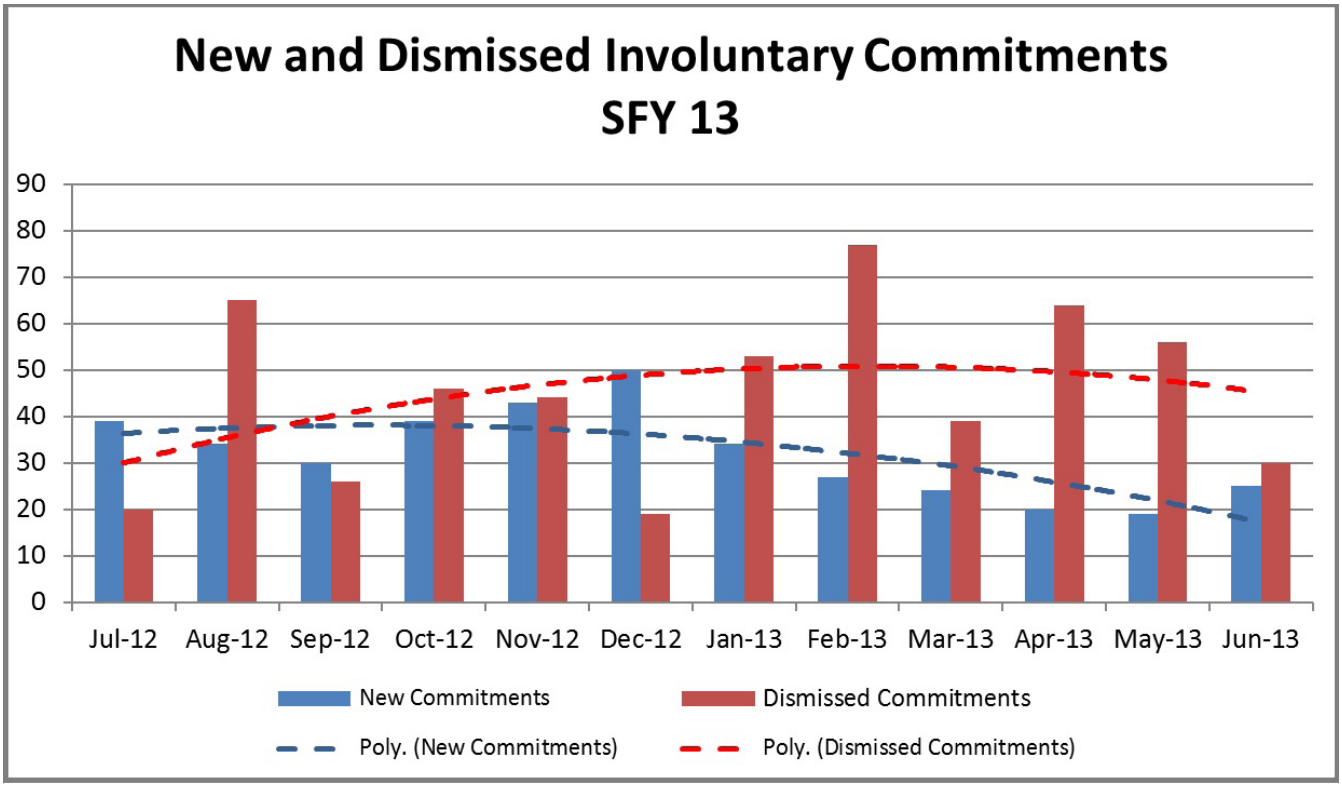



**Figure 1:** New and Dismissed Involuntary Commitments; July 2012 through June 2013
Data maintained by the Paralegal assigned to DPC and who participated in weekly commitment hearings. The corresponding color lines show new commitments dropping and dismissals increasing.

### *Involuntary Civil Commitment: HJR 17 Committees Measurements (continued)*

the consumer. The Capias requires involvement of law enforcement officials who apprehend and detain consumers in a similar manner as they would a suspected criminal. Such a process would make it appear as though a person is being treated as a criminal because he/she has a mental illness. In some circumstances consumers have been picked up by police while at work or eating dinner. Further, the existence of a Capias will cause a client to be denied access to a homeless shelter.

**Final Outcome:** Delaware's legislature created the House Joint Resolution 17 (HJR 17) Study Group, chaired by DHSS Secretary Rita Landgraf. The HJR 17 Study Group recommendations for changes in Delaware's Civil Mental Health will be presented to the General Assembly in January 2014. The recommendations will include specific changes to Delaware's civil mental health laws.

Professional training regarding the commitment process--a significant factor in any area in which changes are being made--is being suggested for all presiding Commissioners, Deputy Attorneys General who serve as State's attorneys, and the individuals serving as respondents' attorneys; all of whom play major roles in the hearings. Additionally, doctors who testify at these hearings also will be trained on the changes occurring in the involuntary civil commitment process.

A benefit associated with this work has been the marked reduction of individuals placed on outpatient commitment and a larger number of commitments dismissed. There is a significant increase in the number of commitments dismissed in 2013, which included a large number of very old commitments. Though there may be many additional steps to be taken in the future, Delaware has drastically changed the involuntary commitment process.

## Crisis Intervention

In addition to the revisions of the legal system, including the certification of Mental Health Screeners, and in rethinking involuntary commitment versus voluntary commitment, DSAMH examined other ways that individuals entered the mental health system. Specifically, Delaware's Mobile Crisis Intervention Services (MCIS) in 2010 were not statewide nor did the Unit provide for 24/7 access. Delaware only had one continuously operating Mobile Crisis Unit based in New Castle County. It was almost impossible for the MCIS team to drive to Sussex County to manage a crisis within a timely period (the Settlement Agreement defines "timely" response as "within one hour")

The State was directed to ensure that any crisis anywhere within Delaware could be attended to within an hour of the crisis call. DSAMH established a Mobile Crisis Intervention Services (MCIS) team for Sussex and Kent Counties to address that need. The team is based in Ellendale (Sussex County). Below is a report on the development and success of the team.

### *Mobile Crisis Intervention Services*

**Issue:** Maintaining 24 Hour Crisis Services

Mobile Crisis Intervention Services (MCIS) is a unit of the Division of Substance Abuse and Mental Health (DSAMH) that manages a 24-hour crisis hotline and is charged with responding to crisis situations in the community. Historically, the unit was fully operational in New Castle County, but operated with limited capability in Kent and Sussex counties, especially in regard to mobile response. The U.S. Department of Justice (USDOJ) settlement agreement mandates that a full range of 24-hour crisis services be readily available across the state, including a 24-hour hotline and mobile response teams. Additionally, MCIS must be able to respond to a person in crisis in the community inside of one hour, anywhere in the state, around the clock.

**Background:** MCIS has been a critical part of community mental health services in Delaware, serving anyone in the state, regardless of their ability to pay, insurance coverage or compliance with treatment. Prior to the USDOJ settlement, data regarding MCIS crisis call response times were not tracked, so the previous average response time is not known. One administrator was responsible for managing both the Northern and the Southern MCIS units and the Southern unit was only partially operational prior to 2012.

As part of the revision of MCIS, it was determined that an additional crisis location was necessary in Sussex County, which has greatly increased interaction with Kent and Sussex counties while steadily reducing response times. In 2012, Southern MCIS unit staffing was increased and a full-time downstate manager was hired. By September 2012, Southern Delaware MCIS was fully operational. Bringing this downstate unit fully online has enhanced service delivery in all three counties. In addition, a walk-in crisis center was established in Sussex County and is running efficiently.

**Final Outcome:** DSAMH now has two fully staffed and functioning MCIS units, one in New Castle and another in Ellendale, each with an independent administrator on site and both with a 24-hour hotline and mobile capabilities. As both programs have focused on hiring and becoming fully staffed, the ability to meet the one-hour response time has progressively improved. Within-the-hour response times for the Northern MCIS unit have improved from 88% in December 2012 to 96% in April 2103 (*see* **Figure 2**, page 13). Southern MCIS within-the-hour response times have steadily increased as well, from an average of 85% in March 2013 to 94% in April. The walk-in crisis center has remained consistently busy and continues to be a 24-hour resource for residents in Kent and Sussex counties.

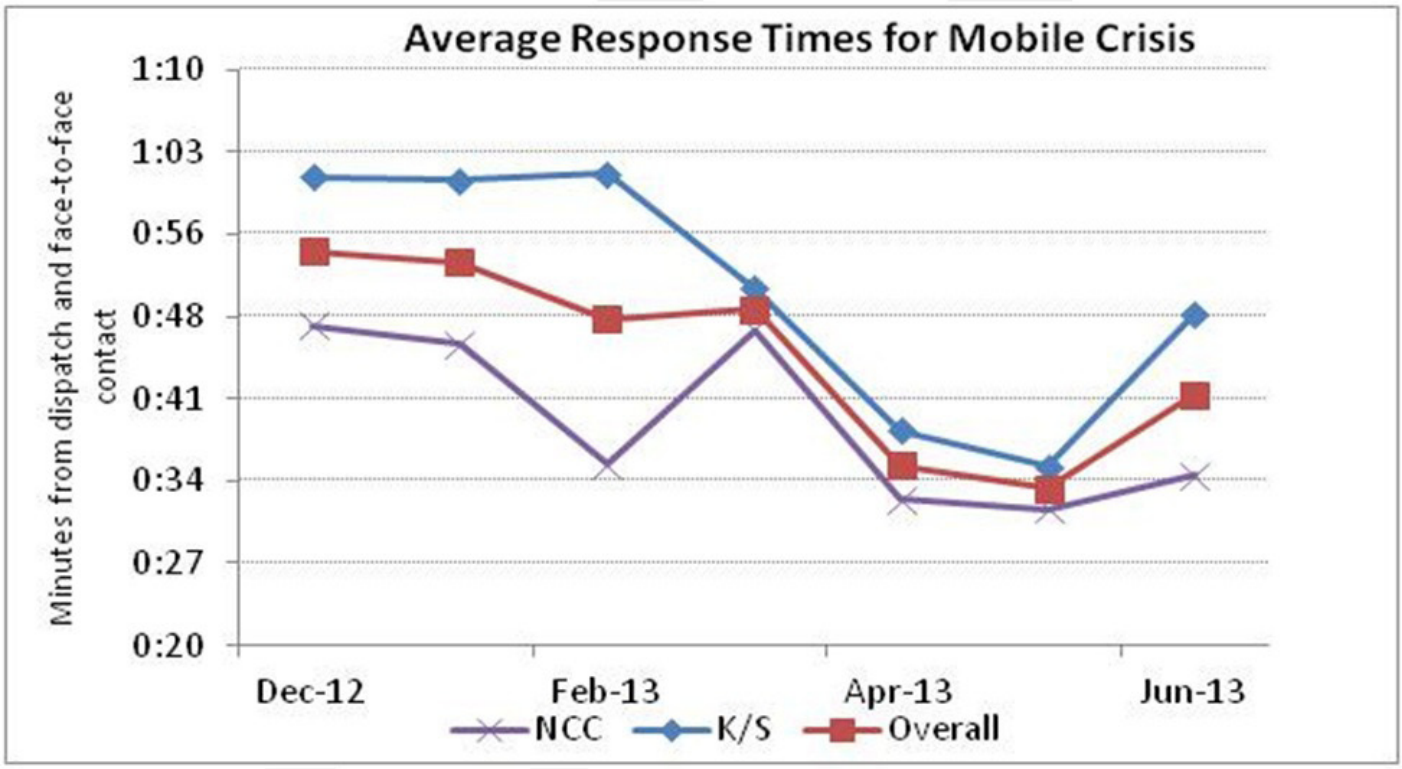



**Figure 2:** MCIS Response Time (Hrs:Mins) by Month – December 2012 through June 2013

**Support Services**

The Olmstead Decision illuminated the need for community-based services that would allow people with mental challenges to receive treatment and live in the most-integrated, least-restrictive setting. The Settlement Agreement addressed the requirement for the State of Delaware to provide integrated housing throughout the State.

The State Rental Assistance Program (SRAP) is a housing voucher program that provides monthly rental subsidies for clients. Clients are issued vouchers to rent a housing unit and a rental subsidy is provided toward paying the rent. The management and implementation of the SRAP program is a partnership between the Delaware State Housing Authority (DSHA) and DHSS.

The Supervised Apartment Program is another housing option for clients with serious and persistent mental illnesses (SPMI). Prior to the Settlement Agreement, each of DSAMH's treatment service providers were given DSAMH funds to provide housing and services to their clients. This did not empower the individual with a choice as to where s/he lived. Before 2011, DSAMH-supported clients were forced to live in housing managed by their service provider. At that time, if individuals switched their primary service provider that meant that they also needed to change housing.

DSAMH unbundled housing from provision of treatment services, retaining an independent property management company to hold master leases for all supported apartments. Today, clients have access to any one of the apartments that are in the master lease program regardless of who provides their treatment services. Additionally, DSAMH has contracted with a treatment provider to offer 24/7 on-site supervision independent of the clients' assigned service providers.

### *Supervised Apartment Structure*

**Issue:** Revisions to the Supervised Apartment Program

The Supervised Apartment Program (SAP) is a housing program that provides housing and services to mental health clients of the Division of Substance Abuse and Mental Health. For years, the SAP was managed by the treatment providers: each provider offered both housing and services to their clients. This model did not offer choice to the clients for housing or community mental health services.

**Background:** For years, the treatment service providers were awarded funds to cover both the cost of renting, typically, two bedroom apartments and providing 24/7 on-site services to assist the clients in their Activities of Daily Living (ADLs) and other needed services. The providers would use the housing for their own clients and rarely provide units to clients receiving treatment from another organization unless the responsibility for the client's treatment was ultimately transferred to the service provider who had the housing.

As part of revising the mental health system, DSAMH determined that the SAP's design did not give the clients choice in either housing or their treatment provider. Unbundling the housing and treatment services would afford clients more choice. In the new scenario, regardless of which treatment provider is assigned to the client, the client has the choice of location for housing and the ACT/ICM Team will follow him/her – not the other way around.


DSAMH determined that a property management company was needed to manage and rent the apartments to the clients though a master lease program and the supportive/supervisory client services would be provided by a separate organization that did not have a contract with DSAMH to provide ACT/ICM services.

**Final Outcome:** DSAMH issued a Request for Proposal for a property management company. Columbus Property Management (CPM) signed a contract with DSAMH in March 2013 and by June 1, 2013 all the SAP apartments that were leased by the original service providers were under new master leases between the landlords and CPM. DSAMH identified a current vendor within the DSAMH system, Recovery Innovations (RI), to provide the 24//7 supervisory/supportive services at each apartment complex. RI does not provide ACT/ICM treatment services to clients in Delaware.

Clients receiving ACT/ICM services apply for housing through DSAMH Housing Unit. Placement is by date of application and the client has choice of where s/he lives and with whom, if a roommate situation is desired. The 24/7 supportive services are provided by RI. In collaboration with the ACT/ICM Teams, RI facilitates activities on site or reaches out to the service providers when there are perceived issues with the clients.

Another supportive service is Supported Employment. The Settlement Agreement and the State recognizes the importance of employment in a person's recovery. DSAMH also has understood the need for employment and for several years has partnered with the Division of Vocational Rehabilitation (DVR) to finance staff in the service provider community to coordinate supportive employment.

### *Supportive Employment*

**Issue:** The Division of Substance Abuse and Mental Health (DSAMH) is in the process of creating and hiring a full-time contracted position that will focus exclusively on the provision of employment and supported employment services to the DSAMH clientele.

**Background:** DSAMH and the Division of Vocational Rehabilitation have had a long-standing and positive relationship which has resulted in solid employment rates among individuals served in the DSAMH system of care. However, the changes to the DSAMH system have begun to erode some of the gains made over the past several years. DSAMH program clientele do not always have access to employment supports and employment opportunities as soon as they are ready to work. In addition, the USDOJ settlement has set employment targets that the State must meet. While DSAMH is making progress in employment of its clientele, the Settlement Agreement calls for substantially more individuals to be employed over the next three years.

**Outcome:** DSAMH will hire a full-time position whose sole responsibility will be the development and support of employment services, particularly within DSAMH provider organizations that support individuals on the USDOJ Target population. These organizations primarily operate the newly developed programs that resulted from the Settlement Agreement. The Division has already developed a housing coordinator whose role is the development of housing resources and assistance to providers in accessing these resources. DSAMH believes that the addition of a singularly-focused, full-time position for employment services will assist the division and its contractors in meeting not only the USDOJ Targets, but also in finding meaningful and competitive employment for individuals who, historically, have had trouble accessing work.

## Partnerships

The Settlement Agreement is about assuring excellence and choice in service delivery for persons who are receiving services for Serious and Persistent Mental Illness (SPMI) funded by the public system; either via Medicaid and/or DSAMH funding. DSAMH and the Division of Medicaid and Medical Assistance (DMMA) have forged a partnership to ensure the Targets of the Settlement Agreement are met and that clients are receiving the best coordinated care possible.

Below is an example of this partnership to provide the best services for clients.

### *Enhancement of Medicaid-funded Services*

**Issue:** Enhancement of Medicaid- funded services to more fully support the Delaware publicly funded system of care.

**Background:** Medicaid funding is a critical component for funding behavioral health services in Delaware. Due to the fact that it is a State/Federal partnership, it allows States to leverage funding to support and expand services.

DSAMH and the Division of Medicaid and Medical Assistance (DMMA) have collaborated in the development of a two-phase plan to enhance the delivery of Medicaid-funded behavioral health services in Delaware

**Changes to the Medicaid State Plan**

DMMA has submitted a State Plan Amendment that will:

- Remove mental health clinics from the Medicaid Clinic Option and cover the services provided in those facilities in the Other Licensed Practitioner section of the State Plan. This will allow Medicaid reimbursement for Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, and Licensed Marriage and Family Therapists when services are provided in a clinic or community setting as permitted under State practice laws.
- Include Crisis Intervention and Outpatient and Residential Substance Use Disorder Treatment under Rehabilitation Services. This will allow the State to provide Medicaid-eligible individuals with mobile and site-based crisis intervention for individuals experiencing a behavioral health crisis. In addition, the State will be able to provide recovery-oriented treatment for individuals with substance use disorder.

**Changes to the Demonstration Waiver**

DMMA is finalizing an amendment to the Section 1115 Demonstration Waiver to:

- Introduce home and community-based supports to ensure that individuals with SPMI receive the supports necessary to successfully reside in the community. Eligible individuals will be over the age of 18, have a diagnosis of SPMI, and meet needs-based criteria using the Delaware-specific American Society for Addiction Medicine assessment tool that evaluates both mental health and SUD.

**Final Outcome:** The changes presented above will be phased in over the next 12-15 months. This enhancement of Medicaid- funded services, in conjunction with the expansion of Medicaid eligibility for adults under provisions of the Affordable Care Act, will greatly improve the delivery of behavioral health services in Delaware and better support the community system of care.

**Peer Activities and Peer Run Services**

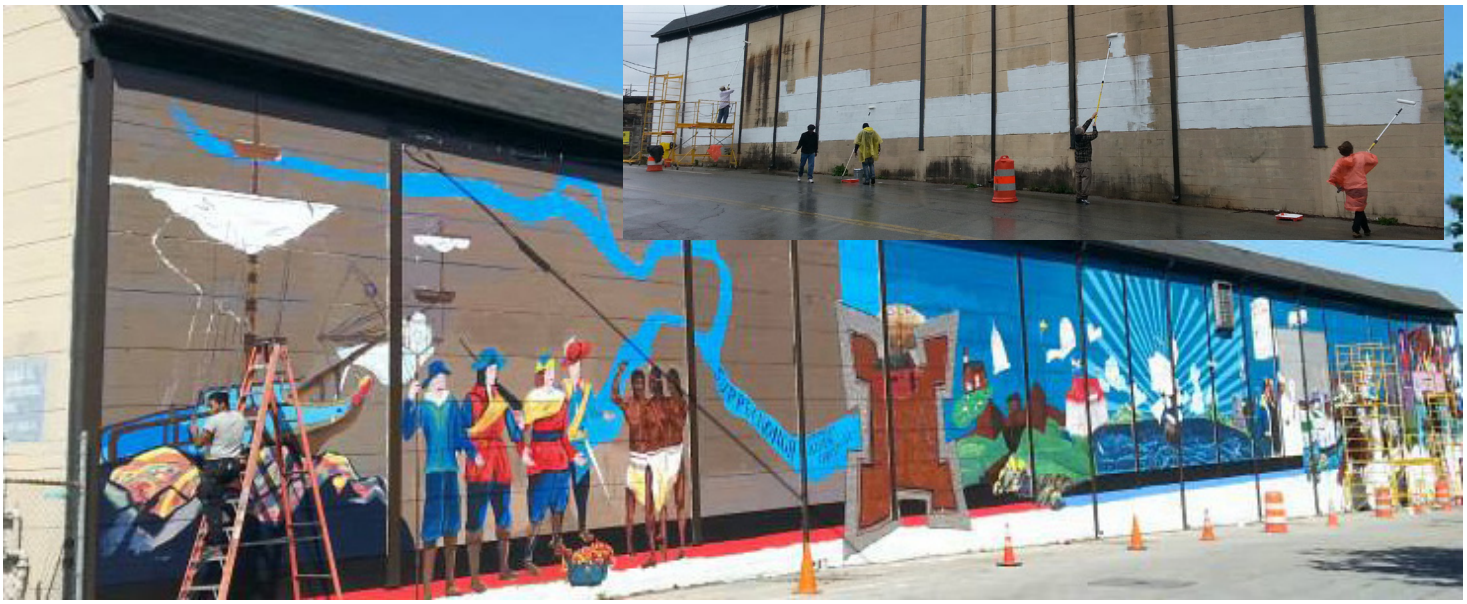
Delaware has had Peer-Run Programs and Peer Community Centers for several years. (A Peer is a person who self-identifies as having lived experience with mental illness and/or substance use recovery and who works with persons with a mental illness and/or substance use disorders.) Prior to the Settlement Agreement there were three Peer- Run Drop-in Centers in New Castle and Kent counties. The Peer-operated programs were administered by organizations that also operated other programs that were not necessarily staffed by Peers.

In general, the managing organizations did not hire Peers to work in their other service programs and did not have a strong Peer organizational culture. For example, it would have been unusual for Peers to be members of the clinical team. The Peer movement has matured in Delaware as a direct result of reform efforts.

DSAMH has incorporated the Peer philosophy in all aspects of its internal operations and has instituted a requirement in the service provider contracts that Peers be included on clinical treatment teams as well as in other program areas. The Assertive Community Treatment (ACT) teams, Intensive Case Management (ICM) teams and the Targeted Care Management (TCM) teams all have Peers as part of their staffing pattern. There are Peers based in the Delaware Psychiatric Center, included in the Supervised Apartment Program service staff, included in each of the treatment service provider organizations, and the Drop-In Centers are now managed and led by Peers. Overall, the Peers are employed in all the service provider organizations as well as leading their own viable community organization.

In FY13 the DSAMH Peer staff, led by Gayle Bluebird, developed a Certification Program for Peer Specialists that includes several days of training, culminating in a test on the materials and a formal Certification by the State. Peers who are employed by local non-profit organizations are attending the training and sitting for the examination. The Peer movement in Delaware is powerful and influential in service delivery for persons with SPMI.

In order for DSAMH to support the Peer movement and empower Peer-run organizations to become independent, DSAMH has adopted in concept, the Administrative Services for Peer-Run Organizations model from Substance Abuse and Mental Health Services Administration (SAMSHA) and instituted it in Delaware.



Artists, associated with Wilmington's Peer-operated Creative Vision Factory, transform a warehouse wall into a colorful landmark on the Seventh Street peninsula, commemorating 350 years of the area's history. Kalmar-Nyckel Foundation commissioned the work.

### *Administrative Services Organization for Peer-Run Organizations*

**Issue:** Administrative Services for Peer-Run Organizations

The effort to infuse Peer-Run Services into the DSAMH system of care began about five years ago. The program was initiated by awarding additional funding to an existing agency providing services to the target population. Subsequently, additional Peer Run Centers were similarly established. The Peer Run Centers obtained 501(c)3 status, initially under the auspices of a traditional service provider. After that, they have maintained a relationship with a service provider who acts as the fiscal agent for these centers, is a member of the Peer Run Center Board of Directors and offers assistance when requested. The need for independence and accessibility to any one of the Peer Run Centers, by all DSAMH clients (championing client choice), spurred a rethinking of this arrangement.

**Background:** DSAMH has created a robust Peer Specialist network serving the state-run Delaware Psychiatric Center (DPC) residents as well as consumers in the community. As DSAMH has matured in this endeavor through training and nationally recognized expert involvement, it became apparent that the Peer-Run Centers needed to evolve as well.

DSAMH determined that these centers, as they became able, needed to be given the opportunity to operate as independent entities without service provider influence and oversight. The concern has been that the Peer Run Centers have not been prepared to fully manage all the responsibilities related to their 501(c)3 status. Particular areas of concern are fiscal operations and human resources functions.

**Final Outcome:** DSAMH adopted the definition, promulgated by the Substance Abuse and Mental Health Services Administration (SAMSHA) that identified Peer-run service programs as programs that are owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational approach. DSAMH issued a Request for Proposal for an Administrative Services Organization (ASO) consistent with that definition. The role of the ASO will be to train and educate Peer Program leaders toward independence as outlined by SAMHSA.

Clients in recovery from substance use disorders join hands in a huge circle in a ceremony affirming their commitment to recovery during the annual Recovery Month Softball Tournament in Sussex County co-sponsored by DSAMH and several treatment service provider organizations.

**Overall System Revisions for the Division of Substance Abuse and Mental Health**

The Division of Substance Abuse and Mental Health provides services to clients who either have a co-occurring disorder, a mental health disorder or a substance use disorder. DSAMH thought it prudent to revise the substance use disorder (SUD) system along with the mental health system to ensure coordinated service delivery for all aspects of behavioral health.

### *Revision of Substance Use Statewide System*

Issue: Outdated Treatment and Programs for Substance Use Disorders (SUD)

SUD services had not been comprehensively reviewed for more than ten years. Recent advances through Evidence-Based Practices (EBP) and Medication-Assisted Treatment (MAT) were not incorporated into service provision.

Background: What was/is in place has been a "silo-ed" system of care, lacking continuity, integration or accessibility. There are multiple reasons for change coming at this time:

1. Changes in State Medicaid Plan
2. Application to provide new "1915(i)-like" Home and Community-Based Services under a Medicaid Section 1115 waiver demonstration project
3. Affordable Care Act (ACA)
4. Opiate and Addiction Epidemic
5. Advances in MAT– Medication-Assisted Treatment
6. Evidence-Based Practice acceleration


DSAMH has a philosophy that behavioral health is essential to overall health; that prevention is possible for many of these conditions; treatment is effective; and people recover. The approach will continue to push the use of evidence-based and promising practices throughout the system. Integration of both mental health and substance use disorder services is important so there is no wrong door and people seeking services can get them wherever they enter.

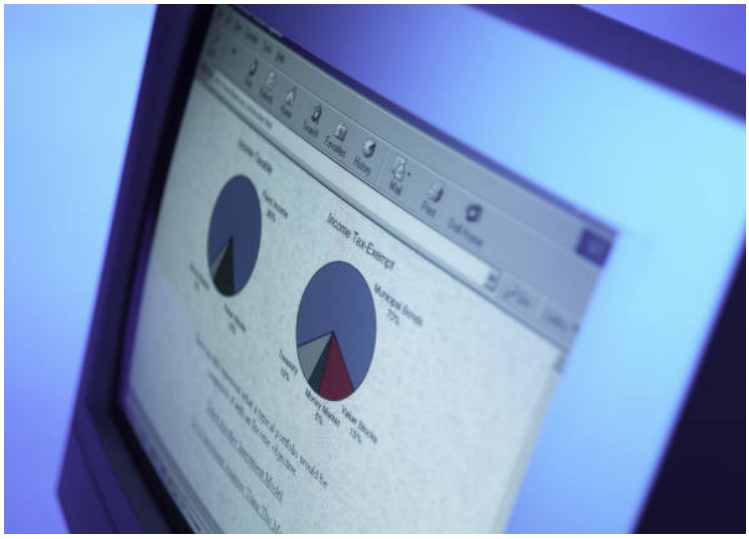
The integration of primary care services for many clients of DSAMH with mental health and substance use disorders is another major goal. All people with serious mental health disabilities are vulnerable to a number of serious physical problems that have led to national research finding that people with serious mental health concerns die up to 25 years earlier than the general population.

A DSAMH team conducted an assessment of substance use disorder treatment, focused on what should remain unchanged, what needed to be transformed and what was missing in the continuum, as well as the funding mechanisms required to achieve the goals.

Final Outcome/On-going initiatives: As noted above, DSAMH and DMMA are at work on changes in funding mechanisms that will enable additional services. There is a concerted effort to apply the same rigorous examination and revamping of the SUD treatment system as has been brought to bear on the mental health system to improve accessibility, ensure best practices and enhance positive outcomes.

## SECTION II – RECOMMENDATIONS (FROM THE COURT MONITOR) AND CHALLENGES (TO IMPLEMENTING THE RECOMMENDATIONS)

The Accomplishments Section highlighted the successes that have been made beyond meeting the Targets. The Recommendations and Challenges Section features three areas of needed improvement–data, oversight of inpatient and outpatient commitment, and management of inpatient bed days in the hospitals–as stated by the Court Monitor.



The Court Monitor meets monthly with representatives of the State agencies, particularly DSAMH and the DHSS Cabinet Secretary, on Settlement Agreement issues. Semi-annually he files a report with the U.S. Department of Justice (USDOJ) on the progress made by the State.

In each of his reports, the Court Monitor reviews the status of the Settlement Agreement Targets and the progress of reform of the mental health system. Below are the most common recommendations and the challenges the State faces in implementing the reforms.

Specifically, each Court Monitor Report identified three foundational areas that are necessary to facilitate the changes currently being adopted by the State:

- Data Systems and Data Collection;
- State Oversight of Involuntary Inpatient and Outpatient Commitment; and
- Management of Admissions for Publicly Funded Clients (DSAMH and Medicaid) into psychiatric hospitals, and the relationship between the Division of Medicaid and Medical Administration (DMMA) and DSAMH on best practices of coordinating services for those in the target population.

### Data Systems and Data Collection

The collection of data is integral in establishing a solid foundation for the mental health system. Without data, DSAMH, the DHSS Cabinet Secretary, the State, and the USDOJ will not have a benchmark by which to measure the State's success in caring for clients, and in developing programs and supports to serve them.

Traditionally, the system of gathering information has been fragmented and disjointed. The staff of DSAMH has maintained records but typically there are multiple data sets, and the records and data are not integrated. More importantly, when the data is collected and reports are generated, DSAMH does not have the analytical capacity to use the data as a management tool.

Data collection and management are essential in the 21st Century. DSAMH has been moving forward in its efforts to collect and analyze data to establish trends and make appropriate management decisions. DSAMH is in the process of implementing an Electronic Health Record system.

In his reports, the Court Monitor's review of DSAMH's data issues focused on several key issues:

- the lack of up-to-date information technology systems to collect the data;
- the fragmentation between DSAMH units, DHSS Divisions and State Agencies in collecting the data;
- the lack of analysis of the data; and
- the lack of use of the data as a management tool to understand current outcomes, analyze trends and forecast future outcomes.

The Court Monitor addresses the data issue in the two reports for FY13:

***Court Monitor Report, March 8, 2013***

**Data Systems**

"Previous reports of the Monitor have noted that Delaware is hampered by very much outmoded data systems, many of which operate in isolation from each other and which capture data that are not timely. … A much needed comprehensive overhaul of the DHSS's electronic data systems is underway; this should vastly improve the quality and timeliness of data both within and across governmental divisions. It also entails initiation of electronic medical records, which will dramatically improve access to information that is critical to service provision and quality management." (Page 3, A. Data Systems)

*Recommendations:* "It is very important that DSAMH have the analytical expertise to integrate both the information and the service elements, the recommendations from earlier reports to bring the staffing capacity to DSAMH to allow for such analytic expertise not only remain but are strongly suggested for action in the near future." (Page 3, A. Data Systems)

***Corrected Court Monitor Report, September 24, 2013***

**Use of Data**

"While Delaware is proceeding with a program of broad, long-term upgrades to its information technology ("IT") systems, it is also moving forward on some more immediate, and much-needed, expansions of capacities within DSAMH that are essential to its meeting the requirements of the Agreement. These short-term measures are still incomplete, but they are already offering a glimpse of how a fully functional information system can vastly increase the State's abilities to monitor the quality, impact and efficiency of DSAMH's services to individuals with SPMI."(Page 2, A. Use of Data)

*Recommendations:* DSAMH remains significantly limited in its abilities to produce and appropriately analyze data in ways that will maximize its performance. It is important that it quickly move forward on its plans to expand its IT capacities with individuals who are versed in data analysis, as well as the array of services and systems affecting the population covered by this Agreement. (Page 8, A. Use of Data)

DSAMH has been able to address some of the preliminary needs of analytics by acquiring four new staff positions which, in turn, allow DSAMH to dedicate one full-time person to collecting, managing and analyzing the data. Additionally, this position will be able to systematize current data collection and data flow for uniformity and consistency.

Examples of success in the area of analytics are seen in the Court Monitor's Report dated September 24, 2013. DSAMH is now able to analyze and trend some of its data and produce graphs and charts, the information from which is being used to understand current outcomes and drive program expansion. DSAMH's staff person was able to provide numerous graphs and trending charts to the Court Monitor as backup of his finding and recommendations. As an example of using data as a management tool on page 16 through 21 of the recent Corrected Court Monitor's Report is a discussion concerning the success of diversion of clients from hospitalization and the effect the diversion has on the number of inpatient bed days per year. This information is important because the Crisis Walk-In Center in Ellendale, which opened in August 2012, has had a dramatic effect on increasing the diversion of clients from hospitalization to community-based treatment options. The data gathered at the Center in Ellendale can inform DSAMH executive staff on the value of implementing a Crisis Walk-In Center in New Castle County.

The additional benefit of the aforementioned data analysis is the affect this can have on other USDOJ targets–specifically, the thirty percent reduction of inpatient bed days by FY14. The Crisis Walk-In Center, better known as the Recovery Resource Center (RRC), has been a successful contributor in the reduction of inpatient bed days by diverting clients from the emergency room, which thus reduced the likelihood of unnecessary hospital admissions.

## State Oversight of Involuntary Commitment

For many years Delaware has used civil commitment as a primary tool for treatment and management of persons with a serious and persistent mental illness (SPMI). The Civil Code Chapters 50 and 51 have been used as leverage to routinely commit persons to either outpatient or inpatient status. Commitment in Delaware does not provide additional mental health services to the client. As a rule, persons who were admitted to Delaware Psychiatric Center (DPC) or a private psychiatric hospital (Institute for Mental Disease or IMD) were committed involuntarily and then, once they were released, were put on outpatient commitment. The commitment status required the client to comply with a treatment plan and periodically return to court for a review of their compliance. The Court Monitor has pointed out, in his Report dated September 24, 2013, that this method of treatment was not effective. A more effective practice is providing for early intervention and increasing community resources so the clients can be proactive in managing their psychiatric issues.


### Changes in the Commitment Laws

The Delaware Legislature provided key guidance and mandates in redesigning Delaware's mental health system through the passage of House Bill 311 and House Joint Resolution 17 during General Assembly Session 146.

House Bill 311 updated a section of the Delaware Code that, as revised (effective July 1, 2013), provides the framework for ensuring that clients experiencing a suspected mental crisis can be evaluated by credentialed mental health screeners in their communities—in crisis centers, in hospital emergency rooms, or in other provider settings. The aim is to prevent unnecessary inpatient hospitalization by connecting clients to community providers and promoting their successful integration efforts. For those who need to be hospitalized, the statute revision promotes the use of transportation other than law enforcement personnel and the emphasis on the offering of voluntary hospitalization instead of imposing involuntary hospitalizations. These changes afford clients and their families the same dignity and professionalism that would be expected for individuals with any medical emergency.

House Joint Resolution 17 established a Study Group, composed of stakeholder members identified in the resolution, to assess Delaware's civil mental health laws and to specifically look at the need to modernize commitment laws, whether inpatient or outpatient. Viewed as a companion piece of legislation to HB 311, HJR 17 created a Study Group comprised of community and professional leaders in the State. This group will be proposing a comprehensive revision of Delaware's civil mental health laws that will align Delaware's mental health laws with Delaware's goals for its mental health system and needs of the target population, and make it congruent with stipulations of the Settlement Agreement.

The effort to change the laws and legal responses to mental health crisis has included stakeholders representing every aspect of the mental health community, including judicial officers, legislators, clients, medical professionals, community service providers, mental health and consumer advocates and state agencies. This effort is the first of its kind in the mental health system in Delaware.

In February 2013, DSAMH convened a meeting with the CEOs of the psychiatric hospitals to inform them of the pending changes in the commitment procedures. The draft procedures required much more documentation concerning the patient and the reason for a commitment.

> "Further, both the Division and representatives of the State Attorney General's office have been working with providers and the courts to ensure that orders relating to outpatient commitment are based on specific, well justified, and demonstrably least-restrictive requests, with clarity as to what

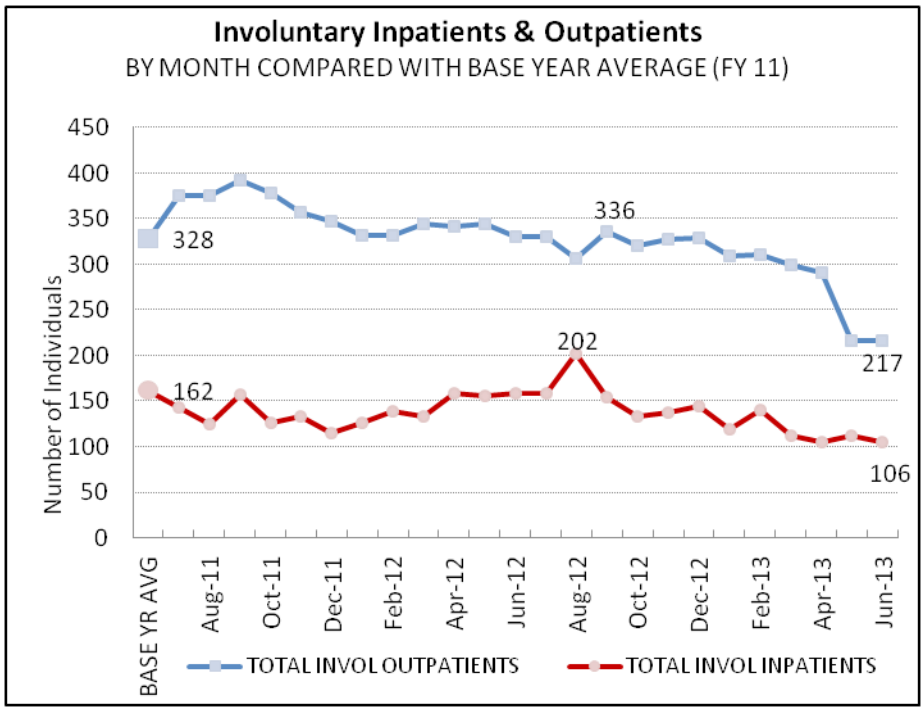



**Figure 3**: Involuntary Commitment August 2011 through June 2013

should be triggered to determine how earlier-on voluntary services might have averted the involvement coercive treatment. Unwarranted involuntary treatment—including court-ordered treatment to reduce providers' perceived liability, assures payment, or as a substitute for good consumer engagement—is not the "least-restrictive" approach consistent with individuals' rights under the ADA and other state and federal laws. Furthermore, absent a specific and carefully considered individual need, coerced treatment is inconsistent with the recovery orientation that DSAMH is pursuing system wide." ***(Corrected Court Monitor Report, September 24, 2013, Page 10, B.)***

is required of the individual to demonstrate compliance." ***(Corrected Court Monitor Report, September 24, 2013, Page 10, B.)***

There have been fewer commitments since February 2013 (see Figure 3).

Additionally, DSAMH has revised its reimbursement procedures to allow for voluntary commitment into the private psychiatric hospitals. This has reduced the pressure to involuntarily commit a client before or within the first 24 hours of an inpatient hospital stay. Until the change in February 2013, DSAMH would only reimburse for involuntary commitments into private psychiatric hospitals (IMDs).

According to the Court Monitor,

"Prior reports by the Monitor have discussed a long tradition in the State's mental health system of relying on court-ordered inpatient and outpatient treatment. In some instances, involuntary treatment was occurring in the absence of clear clinical or legal bases. Furthermore, the policy of DSAMH underwriting the cost of inpatient cares in a private psychiatric hospital ("IMD") only when under court order created the unintended incentive of encouraging involuntary admissions to ensure payment."

"Judicial involvement in mental health care should be a last-resort, emergency measure. When it becomes necessary to turn to the courts, an assessment

House Bill 311 calls for Mental Health Screeners to be trained and credentialed by the State. DSAMH has trained over 200 professionals to serve the state's Emergency Rooms, designated psychiatric facilities and Mobile Crisis Teams as Mental Health Screeners. This includes 12 psychiatrists as well as 142 emergency room-based physicians who took an abbreviated screener training, and 139 other professions who undertook the full 40 hours of training and examination to become Credentialed Mental Health Screeners. Only a trained, Credentialed Mental Health Screener, and/or a psychiatrist can determine if a person needs to be detained for a 24-hour involuntary mental health evaluation.

The above-noted efforts have resulted in a drop in civil commitments. This decrease is important in several ways. First, clients who suffer from a mental health disability are not automatically identified as a person involved in the legal system. Clients do not have their civil rights violated and can decide for themselves as to the treatment modality they wish to pursue. In other states, clients who are taken to court for a civil commitment are able to get additional benefits; there are no such additional benefits available in Delaware to a person who has been committed. In many cases, as represented in the Corrected Court Monitor Report, September 24, 2013 (Page 8), the status of civil commitment does not affect the success of treatment or the follow


Crisis Walk-In Center in Ellendale (Sussex County)

through with treatment.

Management of Admission for Publicly Funded Clients into Psychiatric Hospitals and the Relationship Between the Division of Medicaid and Medical Administration (DMMA) and DSAMH on Best Practices of Coordinating Services for Clients in the Target Population:

The State has met all of the Settlement Agreement Targets for FY12 and FY13. There is one Target for FY14 that may not be met: the Reduction of Inpatient Bed Days. This has previously not been an annual goal or Settlement Agreement Target, but it is a major one for FY14.

The Settlement Agreement, in III. Implementation Timeline: D. Crisis Stabilization Services, states:

"3. By July 1, 2014, the number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 30% from the State's baseline on the effective date of the Settlement Agreement as determined by the Monitor and the Parties."

When the Settlement Agreements refers to "State-funded" clients, it is referring to client care paid for by public funds (DSAMH and Medicaid) payment of which is administered by DMMA though the Managed Care Organizations (MCOs). Clients who require psychiatric services and who receive Medicaid are not typically in the DSAMH system (unless under certain circumstances they have been carved-out from Medicaid and are funded by DSAMH). The partnership between DMMA and DSAMH is critical in appropriately identifying and diverting clients from more intensive/restrictive psychiatric hospital care to less restrictive walk-in centers and 23-hour beds for crisis intervention.

The Court Monitor states that reduction in publicly-funded inpatient treatment "is achievable through a combination of mechanisms, including:

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

***(Court Monitor Report, March 8, 2013, Page 10 E. Inpatient Psychiatric Care)***

DSAMH is implementing the recommendations above. See the Appendix for the status services that are in place or being expanded to meet the needs of the clients.

## APPENDIX – STATUS OF THE SETTLEMENT AGREEMENT TARGETS

In the Settlement Agreement, Section II, Substantive Provisions, Paragraph A states, "In order to comply with this agreement, the State must prevent unnecessary institutionalization by offering the community-based services described in Section II to individuals in the target population." Thus, the Agreement goes on to describe the Target Population and the areas of community-based services that must be enhanced. It defines the Target Population, Community-Based Services and the goals of each. Each goal has benchmarks to be achieved over the five-year course of the Agreement. Progress is measured annually or at intervals relative to the date the agreement was signed.

Section II details "goals set forth in the Agreement and provides" an update on the State's progress in accomplishing these targets, as well as other initiatives. Achievement is assessed at three levels defined in the Agreement:

- ***Substantial Compliance*** means that the State has satisfied the requirements of all components of the target being assessed for a period of one year.
- ***Partial Compliance*** means that the State has achieved less than substantial compliance but has made progress toward satisfying the requirements for most of the components of the target being assessed.
- ***Noncompliance*** means that the State has made negligible or no progress toward compliance with all components of the target being assessed.

### Transition Planning

In the Settlement agreement, "Section IV A sets forth requirements for person-centered recovery-oriented discharge planning, including the requirement that individuals be assessed from the perspective that, with sufficient supports and services, they can live in integrated community settings."

***Substantial Compliance***

"Delaware continues to make important advances in achieving these reforms. For example, the person-centered Community Living Questionnaire that was developed at DPC to meet these requirements is now being used in the IMDs, as well, with collaboration by community providers. Furthermore, DSAMH continues to require special review of individuals who (generally for physical healthcare reasons) are not being recommended for fully integrated housing upon discharge. In these small number of instances—perhaps a dozen during the course of the past year—the hospital or community provider compiles a detailed analysis explaining why a fully integrated living arrangement is not feasible. These analyses are then reviewed by DSAMH and by the Monitor, sometimes culminating in a time-limited approval for an alternative setting while physical healthcare issues stabilize. This system is working well." ***(Corrected Court Monitor Report, September 24, 2013, Page 29)***

### Crisis Services

In order to deter unnecessary hospitalization, the State was charged with developing a full spectrum of geographically accessible services over the five-year time frame of the Agreement. These services fall under Crisis Services, which are the frequent entry point to care, and include:

- Crisis hotline staffed by licensed clinical professionals 24 hours per day, seven days per week, with toll-free access throughout the state;
- Mobile crisis teams who can work with trained law enforcement personnel to respond to people at their homes and in the community, available to respond within one hour, 24 hours per day, seven days per week;
- Crisis walk-in centers which can provide community-based counseling to individuals experiencing a mental health crisis 24 hours per day, seven days per week;
- Crisis stabilization services, or short-term acute inpatient care, intended to help stabilize clients and discharge them back to the community within 14 days; and
- Crisis apartments, where individuals experiencing a psychiatric crisis can stay for up to seven days to receive stabilization and support services in the community prior to returning home.

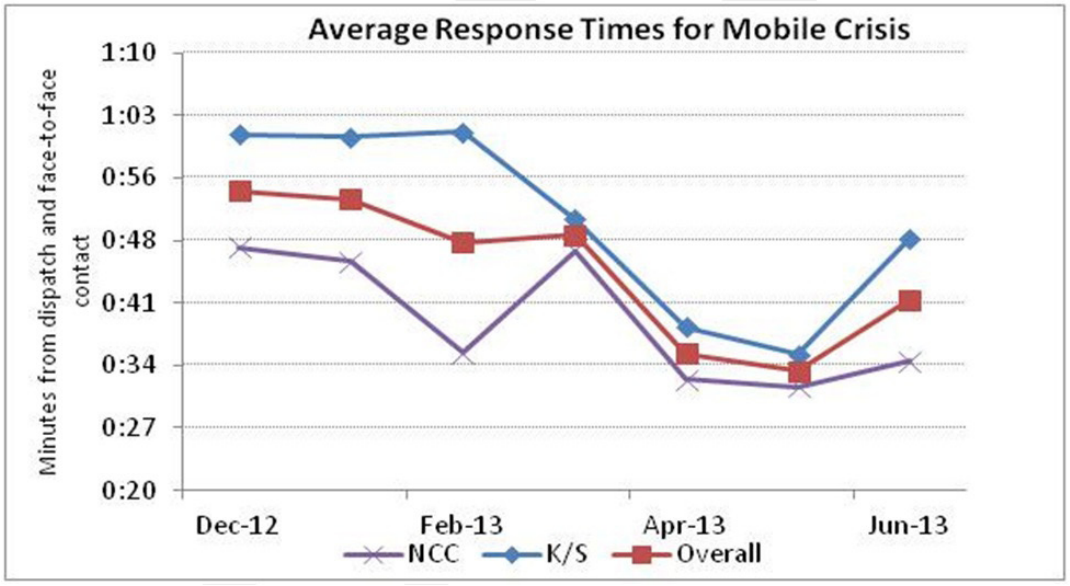



**Figure 4**: Crisis Response December - June 2013

The targets for each of the crisis service components for Fiscal Year 2012 and 2013 and the progress made by the State for each are as follows:

*Crisis Hotline*

- By January 1, 2012, the State will develop and make available a crisis hotline for use 24 hours per day, 7 days per week.
- By July 1, 2012, the State will provide crisis line services publicity and training materials in every hospital, police department, homeless shelter, and Department of Correction facility in the State.
- There are no targets for FY13

***Substantial Compliance***

The State has met its targets and continues to maintain a crisis hotline 24/7 it is also conducting training and providing information to the communities that would naturally use the Crisis Hotline Services. DSAMH maintains monthly data on calls received by the Crisis Hotline.

*Mobile Crisis Teams*

- By July 1, 2012, the State will make operational a sufficient number of mobile crisis teams such that a team responds to a person in crisis anywhere in the State within one hour.
- By July 1, 2013, the State will train all state and local law enforcement personnel about the availability and purpose of the mobile crisis teams and on the protocol for calling on the team.

***Substantial Compliance***

As stated in the Settlement Agreement, "Section III.B.2 requires the State to train state and local law enforcement personnel about the availability, purpose, and procedure for accessing mobile crisis teams. The State is in compliance with this provision; it has an ongoing program of training and consultation with law enforcement personnel across Delaware."

"Furthermore, as required in Section III.B.1, the State is continuing to meet the requirement of a one-hour response time to mobile crisis calls. The chart above demonstrates DSAMH's monthly monitoring of this provision for the teams stationed in New Castle County and Kent/Sussex Counties." ***(Corrected Court Monitor Report September 24, 2013, Page 15)***

*Crisis Walk-in Centers*

- The State will make best efforts to make operational one crisis walk-in center in Ellendale to serve the southern region of the State no later than September 1, 2012.
- By July 1, 2013, the State will train all state and local law enforcement personnel about the availability and purpose of the crisis walk-in centers and on the protocol for referring and transferring individuals to walk-in centers.

***Substantial Compliance***

Although the State has met the FY13 Target the Court Monitor had three recommendations in his Report issued on September 24, 2013, regarding how the state should act on information it had obtained from its experience with the new Crisis Walk-in Center.

"In compliance with Section III.C.1, the State launched the Recovery Resource Center (RRC) in Ellendale…" ***(Corrected Court Monitor Report September 24, 2013, Page 16)***

The State has been collecting data from the RRC for over a year. The data has been instrumental in informing next steps, such as examining needs and

capacity of RRC, expansion of RRC services, and developing a walk-in center in New Castle County similar to the one in Ellendale. Due to the success of the RRC Crisis Walk-In Center in diverting clients from in-patient hospital stays, the Court Monitor has recommended replicating it in the northern part of the state. DSAMH is making headway in meeting the recommendation and hopefully will be able to report in the FY14 Annual Report that a second Walk-In Center based on the RRC model has opened and is diverting unnecessary hospitalizations.

*Crisis Stabilization Services*

- By July 1, 2012, the State will ensure that an intensive services provider meets with every client receiving acute inpatient stabilization services within 24 hours of admission to facilitate his/her return to the community and that the transition planning is completed with standards set forth in the agreement (Section IV of the Agreement).
- By July 1, 2013, the State will train all provider staff and law enforcement personnel to bring individuals in crisis to crisis walk-in centers for assessment rather than to local emergency rooms or private psychiatric hospitals.
- By July 1, 2014, the number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 30 percent from the State's baseline on the effective date of the Settlement Agreement.

***Substantial Compliance***

"[The State] is providing ongoing training to law enforcement, providers and other stakeholders statewide with regard to the use of crisis walk-in centers." ***(Corrected Court Monitor Report September 24, 2013, Page 17)***

The State has made a start on the FY14 Target – reduction of inpatient bed days by thirty percent. The partnership between DSAMH and the Division of Medicaid and Medical Assistance (DMMA) is paramount to the success in meeting this target. DMMA and DSAMH have been working together since January 2013 to strategize on the best practices to reduce bed days. The effort has naturally branched out to the Managed Care Organizations (MCOs) to solicit their assistance in diverting clients receiving Medicaid to seek alternative community services instead of being hospitalized.

The discussion in the Corrected Court Monitor Report, September 24, 2013,Pages 16 through 21, go into detail about crisis walk-in centers and how the center offers effective crisis stabilization and diversion from an inpatient hospitalization.

*Crisis Apartments*

- By July 1, 2012, the State will make operational two crisis apartments.
- By July 1, 2013, the State will make operational a minimum of two additional crisis apartments, ensuring that the four apartments are spread throughout the State.

***Substantial Compliance***

"Section III.E.2 of the Agreement requires the state to make 2 additional crisis apartments available by July 1, 2013, bringing the total number of crisis apartments to 4." ***(Corrected Court Monitor Report, September 24, 2013, Page 21)***

*Assertive Community Treatment*

- By July 1, 2012, the State will expand its 8 ACT teams and bring them into fidelity with the Dartmouth model.
- By September 1, 2013, the State will add an additional ACT team that is in fidelity with the Dartmouth model.

***Substantial Compliance***

"Section III.F.2 requires that the State establish 1 additional ACT team—bringing the total to 9 ACT teams—by September 1, 2013. The State has already surpassed that target. There are presently 11 ACT teams statewide. Nevertheless, there are now waiting lists of individuals in need of ACT services in New Castle County because the teams there are largely at capacity." ***(Corrected Court Monitor Report September 24, 2013, Page 22)***

*Intensive Care Management*

- By July 1, 2012, the State will develop and begin to utilize 3 ICM teams.
- By January 1, 2013, the State will develop and begin to utilize an additional ICM team for a total of 4 teams.

***Substantial Compliance***

"Section III.G.2 of the Agreement required the State to have a total of 4 Intensive Care Management ("ICM") teams operational by January 1, 2013. As was described in the last report, Delaware has surpassed this target, having 5 ICM teams operational statewide." ***(Corrected Court Monitor Report, September 24, 2013, Page 23)***

*Case Management*

- By July 1, 2012, the State will train and begin to utilize 15 case managers.
- By September 1, 2013, the State will train and begin to utilize three additional case managers for a total of 18 case managers.

***Substantial Compliance***

"Section III.H.2 requires that by September 1, 2013, the State will train and begin to utilize 3 additional care managers—termed Targeted Care Managers ("TCM") within the DSAMH system--bringing the total to 18. The State has already met and surpassed this target, having 21 TCMs working in the community and, increasingly, participating in discharge planning at DPC and the IMDs." ***(Corrected Court Monitor Report, September 24, 2013, Page 23)***

DSAMH's longer-range plan is to utilize TCMs as a part of the "front door" for individuals entering public mental health services, with their involvement continuing as needed by the individual.

*Supported Housing*

- By July 11, 2011, the State will provide housing vouchers or subsidies and bridge funding to 150 individuals. This housing shall be exempt from the scattered-site requirement.
- By July 1, 2012, the State will provide housing vouchers or subsidies and bridge funding to a total of 250 individuals.
- By July 1, 2013, the State will provide housing vouchers or subsidies and bridge funding to a total of 450 individuals.

***Substantial Compliance***

"Section III.I.3 requires the State to increase housing vouchers, subsidies and bridge funding so that 450 individuals are served as of July 1, 2013. The State continues to do an exemplary job in responding to this provision. The chart below presents data demonstrating that the State is surpassing its target. During the past year, it has created new integrated supported housing for 221 individuals. Of these individuals, 186 received housing supports through state funded programs (SRAP or CRISP). The total number of individuals receiving supported housing in integrated settings (or in semi-integrated supervised

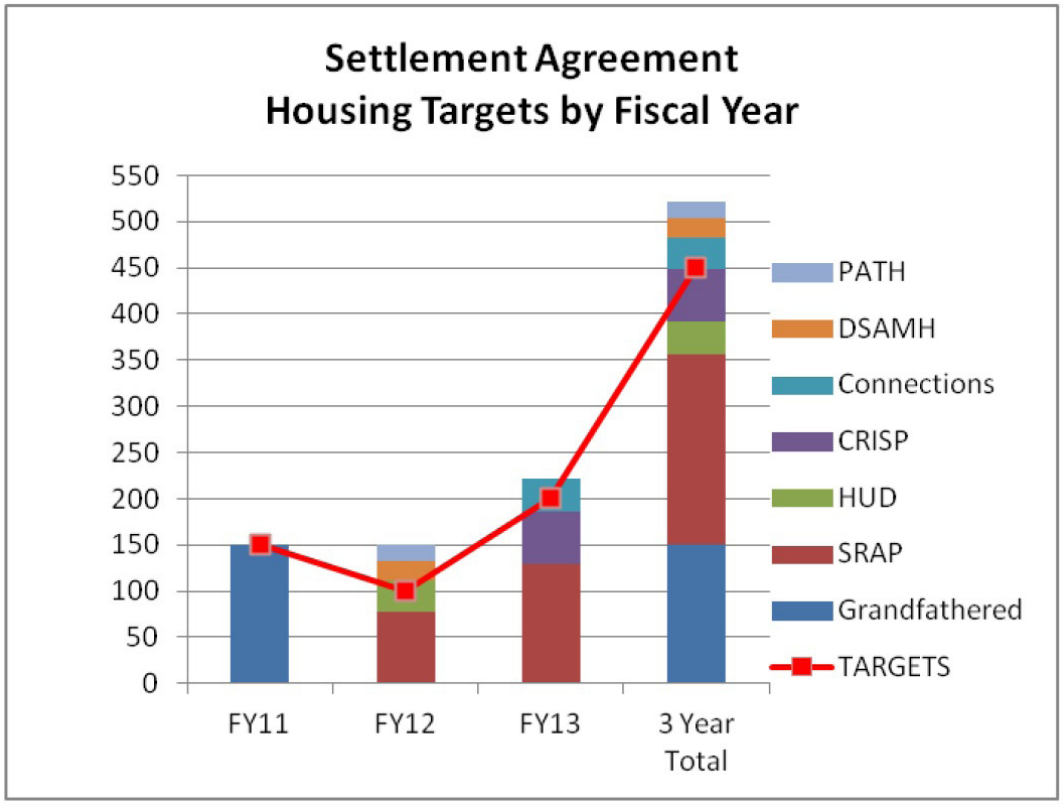


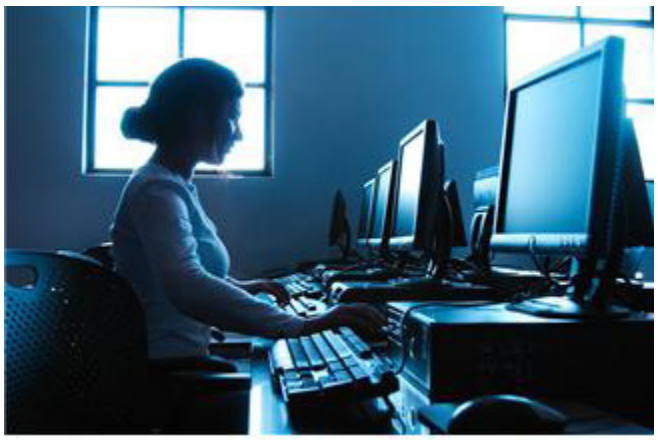

**Figure 4**: Housing Targets FY11-FY13

apartments, in the case of the 150 individuals who were grandfathered in under the Agreement) is 522. In other words, the State is well on its way to achieving its target for July 1, 2014, of 550 individuals." ***(Corrected Court Monitor Report, September 24, 2013, Page 24)***

"Delaware's success in its supported housing program goes well beyond its achievement of the numerical targets of the Agreement. Access to integrated housing with needed supports is fundamental to the ADA's vision of eliminating the social and institutional segregation that have been common among people with serious mental illness." ***(Corrected Court Monitor Report, September 24, 2013, Page 25)***

*Supported Employment*

- By July 1, 2012, the State will provide supported employment to 100 individuals per year.
- By July 1, 2013, the State will provide supported employment to 300 additional individuals per year.



***Substantial Compliance***

"Section III.J.2 of the Agreement requires the state to provide supported employment services to an additional 300 individuals, bringing the total to 400 individuals. There are several levels of employment services provided through the State's Department of Vocational Rehabilitation ("DVR"). For purposes of evaluating compliance with this provision, supported employment services to individuals with serious and persistent mental illness were counted if an individual had progressed through the DVR system to the point that there was an active plan for vocational rehabilitation or, of course, if the individual was being employed at some level and receiving needed supports. During the past year, a total of 569 individuals met these criteria, thus surpassing the Agreement's requirements." ***(Corrected Court Monitor Report September 24, 2013, Page 26)***

*Rehabilitation Services*

- By July 1, 2012, the State will provide rehabilitation services to 100 individuals per year.
- By July 1, 2013, the State will provide rehabilitation services to 500 additional individuals per year.

***Substantial Compliance***

"Section III.K.2 of the Agreement requires the State to provide rehabilitation services to an additional 500 individuals by July 1, 2013, bringing the total requirement to 600. Rehabilitation services comprise an array of activities, such as education, substance abuse treatment, and recreational activities. The State is surpassing its requirements with respect to Rehabilitation Services." ***(Corrected Court Monitor Report September 24, 2013, Page 28)***

*Family and Peer Supports*

- By July 1, 2012, the State will provide family or peer supports to 250 individuals per year.
- By July 1, 2013, the State will provide family or peer supports to 250 additional individuals per year.

***Substantial Compliance***

"Section III.L.2 of the Agreement requires the State to provide family or peer supports to an additional 250 individuals, bringing the total number receiving this service to 500. The State has surpassed its requirements with respect to this provision, providing Family and Peer Supports to approximately 600 individuals." ***(Corrected Court Monitor Report, September 24, 2013, Page 28)***

The Peer Movement in Delaware has been very impressive. In FY13 a Peer Specialist Certification Training was created. As soon as the final credentialing exam has been accepted, Delaware will credential Peers Specialists in a process similar to the credentialing process for Mental Health Screeners or other professionals who require licensure in the State.