

Progress Report on
The First Eighteen Months of Implementation
of the Settlement Agreement
between the U.S. Department of Justice
and the State of Delaware

May, 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 first 18 months of implementation of the Settlement Agreement between the U.S. Department of Justice (USDJ) 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. For us, this isn't merely about meeting the objectives laid out in the agreement. Our approach is about enabling a mental health system that will meet the desires of individuals—our neighbors, friends and family members—to live ordinary lives with identified services and supports. While we have made progress, there are many challenges still to overcome in building the system, and in embedding inclusion and the benefits of diversity as core values in our State.

For Delaware, the Settlement Agreement is the blueprint for how we will provide mental health services to individuals with severe and persistent mental illness who are served by the State's public programs. While the USDJ and the Court Monitor may view the agreement as a way to ensure that the State complies with the Americans with Disabilities Act and carries out the integration mandate in the Olmstead ruling, we also see a more personal benefit. To us, it is about providing services to 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. That kind of inclusion will provide for a better and stronger Delaware.

The robust community system we are building 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 respects and protects individuals' independence, interdependence and sense of community. In the first 18 months, we have identified an estimated 7,000 Delawareans who are in the Settlement Agreement's target population. Beyond the mental health system, the level of reform that Delaware is addressing for individuals with serious and persistent mental illness is seen by us as the prototype for all individuals with disabilities and the aging population in need of supports.

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 crisis hotline to 24/7, added mobile crisis teams that can respond across the state within an hour, opened a new crisis walk-in center in Ellendale, and developed crisis stabilization beds throughout the state in typical apartment settings. In addition, DSAMH has expanded consumer drop-in centers and peer-to-peer counseling. As of July 1, 2012, Medicaid is reimbursing for telemedicine services, which is expanding resources, including psychiatric services to underserved rural areas. DSAMH is one of several partners in the State Rental Assistance Program (SRAP), which subsidizes low-income Delawareans who need affordable housing and supportive services to live safely and independently in the community. And by July 1, 2013, the State will have met its benchmark to provide supported employment to 300 additional individuals per year.

In addition to building a robust community-based system of care, the Department of Health and Social Services supported the reform of Delaware's emergency mental health detainment law and is engaging in a public policy review of the State's civil and criminal mental health laws. On July 24, 2012, Gov. Jack Markell signed legislation providing for credentialed mental health screeners who will 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. The screeners, who are expert in community-based treatment options, will divert individuals in crisis to the most appropriate level of care. In addition, the House Joint Resolution 17 Study Group has spent much of the first five months of 2013 reviewing Delaware's mental health laws and procedures. The Study Group will issue a final report on its recommended changes in January 2014.

The first 18 months of the Settlement Agreement have been filled with important steps forward in reforming Delaware's mental health system. We thank the consumers, families and advocates for helping to inform our implementation. We will need your continued assistance going forward. And we thank all of the other stakeholders who have worked with passion, dedication and commitment to carry out these changes with us.

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

Background

The U.S. Department of Justice (USDOJ) began its three-year investigation of the Delaware Psychiatric Center in November, 2007. 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. During the following eight months, the USDOJ and the State of Delaware negotiated a settlement and signed the Settlement Agreement in July, 2011.



The Introduction to the Agreement states, "...the Parties [to the settlement agreement] intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved."

First Report of the Court Monitor, dated January 30, 2012, noted, "The Settlement Agreement concerns the civil rights of individuals with serious and persistent mental illness (SPMI) who are served in Delaware's public programs."¹

- Passed and signed in 1990, the *Americans with Disabilities Act* requires that state-offered services to residents with disabilities be provided in the most community-integrated settings appropriate to each individual's needs.
- The U.S. Supreme Court decision, *Olmstead v. L.C.*, 527 U.S. 581 (1999), stated that the unjustified institutional isolation of people with disabilities was a form of unlawful discrimination under the *Americans with Disabilities Act*. The Court held that individuals with mental disabilities have the right to live in the community rather than in institutions if, in the words of the opinion of the Court, "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

At the time the Agreement was signed, the USDOJ assigned a Court Monitor to ensure that the spirit and intent of the Settlement Agreement were addressed by Delaware on a timely basis, and that specific targets were achieved and documented over the five-year life of the Agreement. Included in the Court Monitor's responsibilities: to ensure progress by the State according to the Implementation Timeline and to issue reports every six months to the USDOJ on the progress of the State in meeting the defined goals of the Agreement.

Current Situation

Arriving at and complying with the Agreement has been important for several reasons:

- The understanding and recognition that individuals with serious and persistent mental illness (SPMI) can live in the community with the proper support systems like all other Delawareans.
- The cooperation and coordination between state agencies and community service providers allow for the systems change to happen.
- As a small state, Delaware clearly has the opportunity to improve the lives of individuals who have SPMI and their families; and to be a model for other states undergoing the same challenges.
- Although the Division of Substance Abuse and Mental Health (DSAMH) is the primary division that

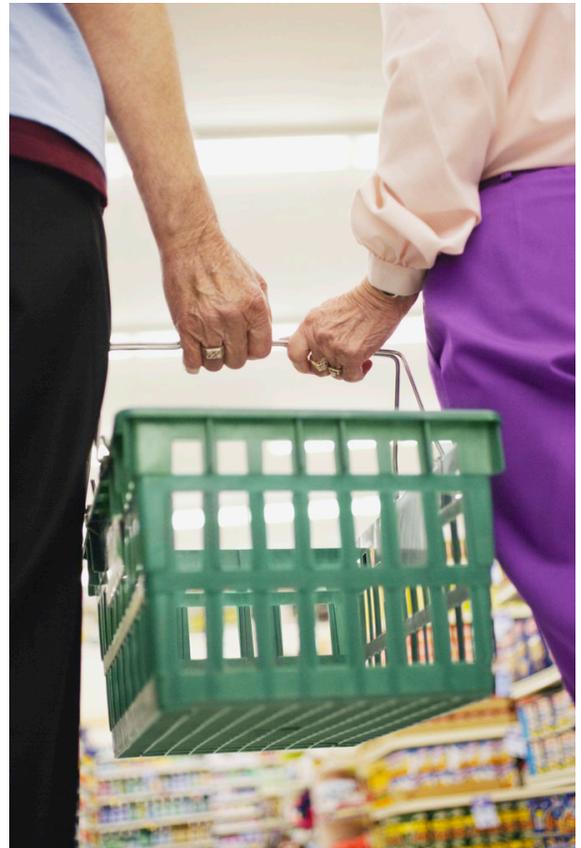
serves persons with SPMI, there are many other state departments, non-profit and private entities that serve persons with disabilities who are protected by the ADA and the *Olmstead* decision; therefore, developing new systems that cross division and department boundaries is critical for statewide compliance with the ADA and *Olmstead* decision.

Significant changes were stipulated with regard to access to housing and treatment services, the delivery of care, the quality of care, and the respect and dignity to be afforded to Delawareans with serious and persistent mental conditions. In the words of the Court Monitor, "These services are designed to prevent or diminish the crises that are now routine among this population and that result in avoidable emergency room use, police involvement, court intervention, and hospital admissions. The Settlement Agreement will enable Delawareans with SPMI to participate as full members of their communities and to overcome the needless segregation, dependency and social isolation that are prevalent today."²

The areas in which system change was required as defined in the Agreement included:

- Defining and identifying the **Target Population**;
- Revising and enhancing the statewide **Crisis Services** System;
- Develop **Intensive Support Services** (a continuum of support services);
- Developing additional **Housing** that is integrated in the community;
- Offer options for people to work through **Supportive Employment** or access education and **Rehabilitation Services**; and
- Expanding the **Family and Peer Services**.

Accomplishing changes in these system areas will require close collaboration with clients, their families, their advocates, their providers, and the state agencies responsible for implementing the complex aspects of redesigning the mental health system in Delaware. Most importantly, it required a shift in the thinking of all Delawareans toward the realization that individuals with serious and persistent mental illness have the same rights as other Delawareans to receive high quality care, community supports, and the opportunity to work, live, and thrive throughout the State in integrated settings.



Eighteen months after signing the Agreement, the State is pleased to report that, through state wide efforts across departments and community providers, using the latest best practices and innovations, and through hard work, Delaware has:

- Designed a new mental health system of care;
- Implemented the foundations of this new system;
- Met the goals set forth in the first 18 months of the Agreement, and
- Is well on its way to meeting the targets for the second year of the five-year Agreement.

This report covers the key challenges faced in the first 18 months of the Agreement. It identifies the key participants, the detailed targets set forth in the Settlement Agreement, along with the accomplishments with regard to meeting the goals of the Agreement and next steps.

KEY CHALLENGES

Mental Health Services Pre-existing System

The legacy system of care for persons with severe persistent mental illness in Delaware relied too heavily on inpatient care and hospitalizations, with a lack of appropriate resources in the community to prevent inpatient stays. This legacy system focused on treatment in emergency rooms, hospitals, and other institutional services as opposed to providing intensive community support services with a person-centered focus. Specifically, the previous system of care did not:

- Provide statewide alternatives to hospitalization for clients in crisis;
- Protect the client from unnecessary interactions with the criminal justice system by reducing police involvement when a client was in crisis and preventing unneeded involuntary commitments;
- Gather, monitor, and trend data on how clients sought and received services statewide so that system stakeholders could make educated decisions on the best ways to deliver efficient and effective services;
- Include peer specialists in providing services to persons with serious and persistent mental illness; and
- Provide a robust system of employment and integrated housing options statewide.

State Infrastructure

- Substantial effort was needed to bring other state agencies critical to implementing the changes up to date on the USDOJ Settlement Agreement and its ramifications for Delaware as a whole; although the suit was born from an investigation of DPC, the USDOJ sued the State of Delaware and the Settlement Agreement objectives had broad-reaching implications for many State services.
- DHSS and DSAMH, with their primary roles in serving the target population identified in the agreement, necessarily focused a considerable amount of effort to galvanize key partners in critical activities such as new hires, revising data collection and issuing contracts to meet timeline requirements; impediments created by state bureaucracy slow positive change in Delaware.
- There remain outdated and/or nonexistent information systems; changes are now underway.
- Recruiting and retaining qualified personnel for difficult-to-fill Crisis Intervention Services Psychiatric Social Worker positions that are considered by the State to be the same as other State merit PSW positions, even though most statewide psychiatric social workers work in low-risk 9 a.m.-5 p.m., Monday through Friday positions. Crisis PSWs are scheduled to work 24/7 in an emergency response environment; but, because of merit classification, unlike other 24/7 jobs, Crisis PSWs receive neither shift differential pay nor hazard pay for their work.

Managing Existing Operations While Designing and Implementing a New System of Care

- To enable the changes, DSAMH released five major Requests for Proposal (RFPs) in a period of 18 months. This resulted in stresses within DSAMH as internal staffing and infrastructure needs did not figure largely enough in negotiating agreement timelines with USDOJ. Two years later, the Division is in a better position, due to management of resources, to meet the challenges that come with major system transformation.
- New contracts for the new system of community-based care required the transition 1500 clients to new providers. Also, providers new to Delaware required more financial resources as well as more time for startup than was anticipated by either DSAMH and the new providers themselves. And all providers were faced with the challenge of reorganizing their service provision to meet the new contract model. This resulted in delays and higher costs and a lesson learned for DSAMH.
- As new providers staffed up and existing providers retooled their operations, all providers experienced considerable staff turnover, again contributing to difficult transitions for providers, clients, and their families.

Housing

- Housing, as it was defined by the Agreement (following standards set by the ADA and the *Olmstead* decision) was not an area of expertise within DHSS or DSAMH. Consequently, DSAMH hired a housing expert in November, 2011.
- The providers and the State housing agencies needed information about the Settlement Agreement, its requirements and mandates of the *Olmstead* decision.
- State housing providers needed help identifying and updating procedures to bring them into compliance with the stipulations in the Agreement.
- Some of the biggest providers of housing learned that their existing property portfolio would not meet USDOJ expectations.
- Innovative approaches to resolving the housing challenges were undertaken and continue.



Culture Change

- Throughout the mental health system, from the consumers (peers or clients) themselves, to the service providers—be they non-profit organizations, advocacy agencies, the state hospital or state employees—there had to be a culture change.
- The belief that persons with SPMI cannot take care of themselves and have to be institutionalized in order to live safely and out of danger had to be debunked. People can and do recover from mental illness or, at the very least, can learn the best skills to manage their symptoms with proper supports.
- A new understanding of person-centered treatment and an embracing the principles, agreed upon in the Settlement Agreement, of “self-determination and choice, community integration and services in a community setting to support individuals at risk of institutionalization,” was essential for success at every level.

KEY PARTICIPANTS

A wide array of participants have been working hard through the above-described challenges toward the successful implementation of the new system. They include:

- clients and families who use the services offered by the state;
- individuals within client advocacy organizations;
- peer support networks;
- mental health advocacy organizations;
- housing provider organizations;
- community service providers (both existing and new to Delaware);
- community mental health organizations including the community psychiatric facilities;
- Delaware Psychiatric Center;
- Division of Substance Abuse and Mental Health;
- Department of Health and Social Services
- Other State agencies;
- law enforcement;
- judicial system;
- The legislature; and
- The Governor.

Brief descriptions of the roles of key participants are below. Although not all participants are defined, the following provide good examples:

Client advocacy organizations have been vigorously working in multiple directions to ensure that the proposed system changes are a good fit for the clients, their families, and the community in general. This has entailed a creative consideration of redesigned housing, ongoing client and family supports through personal contact and programs, and strong communications with the legislature and state agencies responsible for implementing the changes.

A **peer** is an individual who has lived experience with a significant mental health condition, who is actively participating in recovery, and who has made a commitment to working with other Delawareans undergoing the same challenges. The State has undertaken an aggressive program of peer involvement. Peer specialists are professionally trained and employed to engage consumers who

No one works harder than clients who are seeking recovery. These vignettes by DSAMH peers give some flavor of the job of recovery as well as highlighting the role of the Peer Specialist as a guide and supporter for clients as they begin to set and achieve their own recovery goals.

She is a prime example of an uphill battle to achieve recovery. She had recently finished a term at Baylor Correctional, after which she spent time in Mitchell, the correctional unit associated with Delaware Psychiatric Center. With **a history of substance abuse and noncompliance with her psychiatric medication**, her behavior had become erratic, volatile, and aggressive. She had become confrontational in public places and with her family, to the point that various family members had obtained restraining orders against her. It is safe to say her life was on a downward spiral.

As we began to work together she started opening up, peeling back her personality like one pulls back the layers of an onion. From the beginning she did her part: religiously coming daily to the Drop Zone Activity Center, on the campus of the Delaware Psychiatric Hospital. **She had some insight into her condition** and recognized the importance of compliance with medication to remain stable. However, sometimes the client would drift into self-pity, "Why does my family treat me this way?" or "Why is my roommate getting on my nerves?" I would often play Devil's Advocate to help her to understand the opposite point of view and her own involvement to the other person's negative reaction. She would sometimes say with a slight smile, "You always take my family's side." I was not taking sides but helping her develop the skill of understanding the opposing point of view.

As the client began to recognize that each coin has two sides, **she realized that she was not powerless** in her interactions with others and began to take responsibility for her contribution to each situation. She realized that while she could not control the other person's behavior, she could control her responses and actions. She dealt with legal issues that could have had dire consequences; instead the outcomes were positive and she was able to manage her anxiety during the process. As things went well, she made it through, and learned **she could face anything**. She met and overcame the discouraging and depressing challenge of waiting months for housing (although she was clinically stable).

Now in her own apartment in the community, she is active at church and attends AA meetings. She still struggles with not being able to interact with her family. As I told her, "working with her on this transition to community," "We only earn a paycheck if we work all week." She is working hard to stay on the road to recovery to earn back her family's trust and welcome. She is more skilled at managing her emotions and is compliant with her medicine and other treatment. **She aspires to better things**, including returning to college. She is friendly and humorous, patient and kind. This confrontational lion has become a mild lamb.

receive treatment through state-funded programs. Employed in hospitals, crisis centers, provider agencies, community centers, state agencies, and organizations in the community, they help clients in pursuit of their own recovery, modeling recovery based on personal experience and, through day-to-day living activities, facilitating community re-involvement through education, the arts, and employment. In the first 18 months of the new system's transition, they have positively impacted the lives of more than 400 Delawareans with serious and persistent mental conditions. Delaware is in the top five states for peer services in the nation.

Community-based providers offer a range of treatment services as an alternative to hospitalization. These providers have undertaken innovative approaches to client care. New community providers have been brought into Delaware to augment the historically strong mental health programming of existing providers with approaches used successfully elsewhere in the United States. The services offered to maintain clients in the community and help to avoid hospitalization include:

- The improvement of crisis services by northern and southern mobile Crisis Intervention Services teams that can respond anywhere in Delaware within an hour, a walk-in facility in Ellendale and additional respite beds throughout Delaware.
- The development of another (in addition to the Crisis Assessment and Psychiatric Emergency Services in New Castle county) 24/7 accessible psychiatric assessment center in Ellendale to serve southern Kent county and all of Sussex county.
- The development of multiple layers of care management to assist clients through their recovery transition from Assertive Community Treatment Teams, Intensive Care Management Teams and Targeted Care Management Teams.
- The introduction of an Intensive Care Management service program for those most in need of support upon their discharge from hospitals: Community Re-Integration Services Program (CRISP).
- The comprehensive inclusion of daily living support services, such as psychiatric rehabilitation, health care, and employment services



DHSS and DSAMH have the lead roles in implementing the Settlement Agreement. The core response has been the behavioral health care system redesign that has entailed:

- The expansion of **prevention-based mental health crisis services statewide**—from phone assistance to 24/7 face-to-face assessments—to help to support citizens in crisis and individualize the level of care needed. This replaces automatically sending people for inpatient services as the first step which is seldom warranted and rarely cost effective.
- The ongoing implementation of **Trauma Informed Care**, that is, an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. This includes the reduction of hospital coercive methods (such as seclusion and restraint) and implementing other best practices.
- DSAMH's new funding that has (1) supported providing **care managers** to individuals receiving services to help them navigate the mental health service system at three levels; (2) been a source of bridge funding needed to fund housing to over 50 institutionalized individuals newly discharged from DPC. Ten more such long-term clients will be discharged by June 2013.

- Last, DSAMH and its providers are working toward the primary goal of teaching people living with serious mental illnesses (SMI) how to better manage their symptoms. This is an evidence-based goal and is significant in terms of outcomes. If people with SMI can be engaged in their own treatment and recovery, then half of the work is done. Meeting this challenge will mean all state and provider staff understand this goal and have the skills to get to engagement.

The Legislature provided notable keys to the ability to redesign Delaware’s mental health system to incorporate best practices and promote the integration of the clients with SPMI into communities. This was the passage of House Bill 311 and House Joint Resolution 17.

- 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 mental health or substance use 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 truly need to be hospitalized, the statute revision promotes the use of transports 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 will rely on input from a Study Group comprised of community and professional leaders in the State. This group will ensure that the mental health laws are consistent with Delaware’s goals for its mental health system, the needs of the target population, and congruent with stipulations of the Settlement Agreement.

The efforts to change the laws and legal responses to mental health crisis have included every stakeholder within the mental health community, including judicial and law enforcement professionals, legislators, clients, medical professionals, community service providers, mental health advocates and state agencies. These efforts are the first of a kind in the mental health system in Delaware.

SETTLEMENT AGREEMENT TARGETS AND ACCOMPLISHMENTS

The Settlement Agreement in 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.

This section 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.

This reporting of the accomplishments covers an 18-month period. Most of the goals are measured on a yearly basis. While the periodic reports by the Court Monitor address compliance achievement levels every six months, this report discusses issues and achievements but does not rate the goals by compliance standards.

Target Population

The target population was broadly defined to include individuals with serious and persistent mental illness (SPMI) within a spectrum of diagnoses with episodic, recurrent, or persistent symptoms which result in functional impairments that interfere with, or limit, their ability to live in the community. Working with the Monitor, the Division of Substance Abuse and Mental Health (DSAMH) arrived at a list of diagnoses which were approved, along with definitions of the priority populations as outlined in the Agreement. These include Delaware residents with SPMI whose care is state-funded (e.g., Medicaid, DSAMH programs) and who:

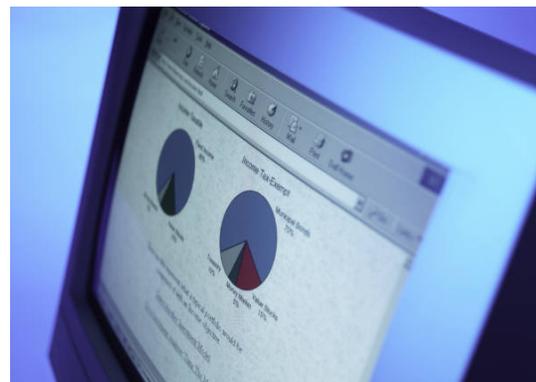
- Are currently at Delaware Psychiatric Center, including those on forensic status; and/or
- Have been discharged from Delaware Psychiatric Center within the past two years; and/or
- Have been discharged from private psychiatric hospitals in Delaware over the past two years; and/or
- Have been receiving services in the community, e.g., CCCP, ACT, ICM, Group Home, CMHCs; and/or
- Have been identified on the target population priority list and been treated in Delaware emergency rooms for mental illness and/or substance abuse over the last two years; and/or
- Have been identified on the target population priority list and had encounters with the criminal justice system over the last two years due to conduct related to their mental illness and have been or are about to be released to community placement; and/or
- Have been homeless for one full year or had four or more episodes of homelessness over the last three years, and have received State-funded services, e.g., PATH program.



The initial step was for the State to determine which Delawareans would be considered to be part of the target population and, within that group, who would be prioritized for care under the provisions of the Agreement. Since July 2011, the State of Delaware, its participating community agencies, and independent hospitals have collaborated to develop an understanding of the number of clients in the target population, their utilization of services, and their need for services going forward. As of January 2013, it is estimated that **there are 7,100 Delaware residents with serious and persistent mental illness** who may be at risk of hospitalization and who are within the designated target population for the Settlement Agreement activities.

Grade By Court Monitor as of Year One – July 1, 2012 – Partial Compliance

In the report issued by the Court Monitor for the end of Year One, the Monitor deemed the State to be in partial compliance with the target population estimation requirements of the Agreement due to outdated data management equipment, techniques and software, and inefficient methods for collecting and maintaining the target population tally on an ongoing and predictable basis. The Monitor also acknowledged that a DHSS-wide overhaul of the information systems is already underway, yet recognized the need for short-term resolutions and the establishment of a blueprint for addressing the data requirements over the long term.



Comments By Court Monitor – March 8, 2013 Report: There is a much needed “comprehensive overhaul of the DHSS’s electronic data systems.” Thus gaining full understanding of the Target Population List continues to be a challenge although DSAMH units, working with sister agencies, have developed “workarounds” that enabled the gathering of the data to “identify the Target Population, understand the services they are currently accessing and better understand the factors that cause individuals to fall into high-risk categories.” (Court Monitor Report March 8, 2013 page 5.)

Crisis Services

To deter unnecessary hospitalization and because use of crisis services frequently is an entry point to care, the State was charged with developing a full spectrum of geographically accessible services over the five-year timeframe of the Agreement, including:

- **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.

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.

Grade By Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State has had a full-time, professionally staffed crisis line in operation since 2012 and has reached out to not only the facilities delineated in the Agreement but to the public as well as via placement of public information notices in public settings on a periodic basis statewide, e.g., shopping mall kiosks.

Comments By Court Monitor – March 8, 2013 Report: None that related to the crisis hotline.

Mobile Crisis Services

- 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.

Renovation of a facility downstate, in Ellendale, to house both mobile crisis and a crisis walk-in center was completed and ready for occupancy on June 25, 2012. The mobile crisis team relocated and continued to be operational immediately, though with several positions unfilled. It remains challenging to recruit and hire mobile crisis workers with the skill sets necessary to effectively care for clients in crisis. The current state merit system reimbursement levels have not proven to be effective in attracting qualified candidates.



As of this Annual Report, the State has addressed the challenge of responding to clients in crisis within one hour. DSAMH has been tracking every call and can show the response time for each call since December 2012.

State mobile crisis service workers, as well as other DSAMH personnel, have been aggressively training and working with law enforcement personnel statewide. The Division anticipates fully addressing this target in a timely and successful manner.

Grade by Court Monitor as of Year One – July 1, 2012 – Partial Compliance

The State was deemed to be in partial compliance with the 2012 target for mobile crisis services primarily because of lack of data collection on a monthly basis.

Comments by Court Monitor – March 8, 2013 Report: The Report by the Court Monitor addressed the “nature of mobile crisis work requires specialized, carefully trained staff and it often presents challenges in terms of recruitment and retention.” The problems of retaining a fully staffed mobile crisis team continued to be an issue during the six months of the interim report. Although there have been challenges of staffing, the success of the mobile crisis teams is demonstrated in the data collected on a monthly basis since December 2012. The State is meeting its target for 2013.

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.

The Ellendale crisis walk-in center (Recovery Response Center) was operational, effective August 20, 2012, and the State was deemed to be in substantial compliance for this target.

Much of the success of mobile crisis services requires community education on the role and accessibility of the crisis walk-in center. Accordingly, state and local law enforcement are being trained on the combined spectrum of services offered in Ellendale and statewide, thereby addressing the target for FY 2013.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was deemed to be in substantial compliance for this target.

Comments By Court Monitor – March 8, 2013 Report: The Ellendale Recovery Response Center (RRC) opened in August 20, 2012. The Court Monitor's report stated that the "program affirmed that RRC is not only designed to address a long-standing unmet need in the southern part of the state, but that it is doing so with a model of service and in a physical setting that are designed to reinforce the individual's ability to recover...RRC had served 650 individuals in mental health crisis."

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.

The targets for crisis stabilization services revolve around transition planning for clients moving from inpatient settings back to their communities, or the avoidance of hospitalizations altogether. Key to successful compliance with the 2012 target for crisis stabilization is the understanding of Section IV of the Agreement, which describes many of the underlying concepts of transition planning. Specifically, implementation components of this section revolve around (1) transition teams for hospitalized clients that incorporate clinical personnel from the hospitals (DPC and the private psychiatric hospitals), representatives from the client's community-based provider, and peer specialists; (2) implementation of discharge planning at the point of admission; and (3) identification of any significant barriers to discharge and options for their resolution.

As of June 30, 2012, DPC and DSAMH personnel had accomplished the following:

- DPC had designed and implemented a new discharge assessment policy and procedures, effective March 19, 2012.
- Meetings were held with the private psychiatric hospitals to discuss having selected elements of DPC's discharge assessment incorporated into their discharge policies and procedures.
- After discussion among the hospitals and DSAMH, agreement was reached to have the private psychiatric hospitals pilot the Community Living Questionnaire component of the DPC discharge assessment. This is an instrument that attempts to engage the client in envisioning how and where that client would like to live in the community, including types of housing, amenities, desired location and other factors that affect successful transition.

Having received feedback on the pilot after June 30, 2012, it was decided that the private psychiatric hospitals would work with DPC and DSAMH to reduce the assessment to a one-page form, relying on Targeted Case

Managers and clients' community providers to undertake the full assessment for clients hospitalized for 14 days or less.

Grade By Court Monitor as of Year One – July 1, 2012 – Substantial Compliance
Crisis Stabilization Services was deemed in substantial compliance.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address this issue in this report.

Section IV. A. Not rated for Compliance:

With regard to the Section IV provisions within this target:

- In Section IV.A, there were no specific implementation milestones, so this section was not rated for compliance. However, the Monitor indicated that the State had undertaken an innovative “Barrier Busters” committee that was “...highly successful in not only problem-solving, but also reorienting transition planning for this population towards a strength-based model of community integration”³
- In addition, the Monitor discussed the State’s development of an innovative, community-based treatment program for long-term state hospital clients, the Community ReIntegration Support Program (CRISP), which provides creative solutions to recovery for one hundred clients and serves as a logical extension of Barrier Busters toward effective transition planning.
- The State was deemed to be in substantial compliance with the transition team requirements set forth in Sections IV.B. 1 and 3 relevant to transition assessments and transitions of clients who pose challenges to living in integrated settings, respectively. However, the Monitor deemed the State to be in partial compliance of Section IV.B. 2, indicating that while the State was monitoring the involvement of community providers and peer specialists in transition planning for DPC clients and clients involuntarily committed to private psychiatric hospitals, expansion of such monitoring to all publicly-funded individuals will be necessary.
- Recognizing the multiple intersections which have taken place between DSAMH, the superior court judges, commissioners, legal advocates, and court personnel for the purpose of dialogue, education, and problem resolution, the State was deemed to be in substantial compliance with Section IV.B.5, which requires the State to educate judges and law enforcement personnel about community supports and services for individuals with mental illness on forensic status.

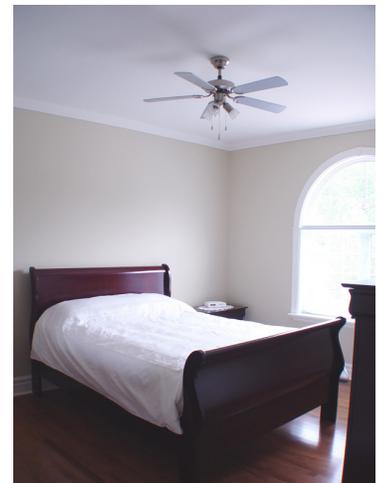
Crisis Apartments

- 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.

In FY 2012, the State documented the statewide availability of six operational respite apartments statewide through funding with community providers. This was deemed to be in substantial compliance for FY 2012 and is currently in excess of the apartments required for the 2013 target. The State has entered into a contract with a provider to add 6 new crisis apartment beds, the result of which is that as of March 15, 2013, there are twelve crisis apartments in the State.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance
Crisis Apartments was deemed in substantial compliance.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address this issue in this report.



Intensive Support Services

Assertive Community Treatment (ACT)

- 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.

As of the end of FY 2012, the State had contracted with 10 teams statewide to provide Assertive Community Treatment programs. DSAMH staff met with the Monitor and suggested upgrading the fidelity requirements from the Dartmouth model to the Tool for Management of Assertive Community Treatment (TMACT) model. Upon review by the Monitor, approval was granted and the ACT teams are currently contracted to be in fidelity with the TMACT model. Transition of clients from the previously existing Community Continuum of Care Provider (CCCP) programs to new ACT teams was in process at the end of the fiscal year, with Kent and Sussex counties completed in June and New Castle County anticipated for July. The State was deemed to be in substantial compliance with this target for FY 2012, and has four providers with 10 teams under contract sufficient to meet the September 2013 target.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was in substantial compliance for the ACT Teams.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address this issue in this report.

Intensive Case Management (ICM)

- By July 1, 2012, the State will develop and begin to utilize three ICM teams.
- By January 1, 2013, the State will develop and begin to utilize an additional ICM team.

As of the end of FY 2012, the State had contracted five teams statewide to provide intensive case management services, with transitions of clients among providers scheduled for completion by June 30, 2012. The State was deemed to be in substantial compliance with this target for FY 2012, and has teams under contract sufficient to meet the January 2013 target.

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.

Late in calendar year 2011, DSAMH released an RFP for targeted care management (TCM), with responses due by the end of February 2012. When only one provider responded, the scope of work within the RFP was recast, and the RFP was re-released on March 19, 2012. This delay resulted in the inability of the State to meet the July 1, 2012 date, as set forth in the Agreement, and the State was deemed to be in partial compliance. The TCM contract was implemented in September 2012, with the anticipation of being able to add an additional 3 case managers in compliance with the 2013 target.

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.

Among the most challenging of the targets in the Settlement Agreement have been the housing targets. Successful matching of client needs, the availability of compliant housing and the existence of appropriate community support services to be provided, and securing funding has been a day-to-day struggle. However, as of July 1, 2012, having met the initial target of 150 vouchers or subsidies and bridge funding earlier in the fiscal year, DSAMH reported funding approval of an additional 151 vouchers for clients within the target population. Ninety-one of these individuals had been matched with integrated housing and moved in, while the additional 60 were at various stages in the process. The State was therefore deemed to be in substantial compliance with the FY 2012 target. Recognizing that clients may relocate or that housing may change, the excess of approved vouchers over the 2012 target provides a springboard to compliance with the 2013 target, as well.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was in substantial compliance for the Integrated Housing Goals.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor indicated that the State was well on the way to exceed the targets for 2013. With the combination of SRAP (State Rental Assistance Program vouchers), the 150 units from 2011 that were grandfathered in, the CRISP (Community Reintegration Support Program) units, and other federally-funded voucher programs will well exceed the 450 target for 2013.

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.

As set forth in the Agreement, supported employment is a service through which individuals receive assistance in preparing for, identifying, attaining, and maintaining integrated, paid, competitive employment. Meeting the target for supported employment means including individuals who have not only attained employment but those who are benefiting from the support services prior to employment.

Neither State nor provider data systems in place during FY 2012 provided accurate representations of those clients who had been in supported employment services. However, working in conjunction with the Division of Vocational Rehabilitation (DVR) within the Delaware Department of Labor, DSAMH was able to confirm the full-time employment of over 128 recovering clients, which had been accomplished in FY 2012.

DSAMH continues to partner with DVR to work with the newly established ACT and ICM teams to regain momentum that was lost in the systems changeover the last year. These teams are still struggling with the hiring and incorporation of employment specialists to augment the work of the teams around employment. DSAMH and DVR have a jointly-funded contract for consultation to help the ACT and ICM teams get up to speed with providing fully-supported employment to clients. It is an expectation of both DSAMH and DVR that employment is a critical outcome of quality care.



Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was in substantial compliance for the Supported Employment and exceeded the target of 100 clients in supported employment.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor noted in his report that DSAMH and the State's Division of Vocational Rehabilitation have a "close and productive working relationship. The value of this relationship is evidenced in recent data showing that the State is far exceeding the requirements of

the Agreement—as of January 2013 a total of 1,049 individuals with SPMI have received active supportive employment services.”

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.

Rehabilitation services include education, substance abuse treatment, volunteer work, recreational activities, and other opportunities to develop and enhance social, functional and academic skills in integrated settings. Weekly requirements for rehabilitation services were set forth in the community provider contracts prior to the first year of the Agreement, along with reporting of these services, and were therefore embedded in the treatment plans for clients going forward.

As of the first quarter of calendar year 2012, 1,395 clients had received rehabilitation services, well in excess of the target. It is anticipated that improved reporting of the true value and impact of rehabilitation services will be available through the ACT teams in 2013.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was in substantial compliance for Rehabilitation Services.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address this issue in this report.

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.

Family and peer support services are provided to families of clients as well as to clients themselves by trained individuals in individual and group settings. Family support services focus on helping families support their family member’s treatment and recovery in the community. Peer support services are delivered by individuals who have personal experience with mental illness and recovery. They help clients identify and use natural supports, develop skills to manage and cope with symptoms of illness and learn about self-advocacy.

Sometimes clients are found by peers to lack the most essential information they need to motivate them on their recovery journey. Self-knowledge is a very empowering tool, as this peer-authored vignette shows.

The twenty-year-old male client with a shy smile had **an extensive history of abuse** by his father. His mother was absent most of his life and as a teenager he was “raised” by a sickly grandfather whom he was charged to take care of. Since his preteen years, he had been experiencing psychiatric symptoms and was hospitalized well over a dozen times. It seemed that the system had just been recycling him—hospitalizing him, then sending him back out into the community with the same set of ineffective tools.

As he and I began to work together, I discovered that his traumatic past affected him in severe ways. He had **a history of self-injurious and suicidal behavior**. He had a very explosive temper that sometimes led to violence; however, he was always friendly and respectful with me. He was really helped by the “Trigger Log” that we completed. Through our discussions he realized that if he could identify the people, places, things, objects and other variables that enraged him, he could prepare a plan ahead of time to de-escalate his anger. We noted the triggers that might set him off and then engaged in role-playing to give him practice handling problematic scenarios. Though initially he lacked self-esteem, **his confidence grew as he realized he was capable** of making good decisions and better controlling his temper. He had been noncompliant with medication in the past, usually discontinuing his medicine when he felt better. As he realized the relationship between his compliance and his mental health, he became more convinced that his compliance was critical to staying well. **Knowing he had some influence over his health improved his self-esteem.**

One discussion I had with him stands out in my mind. We were talking about symptoms and I casually asked, “Do you know what the doctors say you have?” His answer shocked me. **“No one ever told me.”** It was hard to believe that, as a consumer of mental health services for many years, no one had ever explained to him in simple terms why he was often hospitalized. I obtained his diagnosis from his chart and found from a reliable site online listing **14 symptoms of schizoaffective disorder**. Next time I met with him, I asked, “Let’s see if you think this fits you.” Of the 14-symptom list, he identified 10 symptoms that applied to him. Ah ha! There were 10 reasons he kept coming back to the hospital. With this conclusion we were able to go through the list and see how he could make improvements. **He said, “I get it.”**

Now he lives in his own apartment. His most important furniture: his video game system. He is applying for jobs and plans to return to school to take his GED exam. He has phoned a few times to update me and recently came back to the hospital for a visit. He was proud to report that he is doing well. He complies with his treatment, takes his medications and attends therapy. **He is on the pathway to recovery and is smiling more often**—much less shy and much more confident.

Delaware has adopted a very aggressive program of family and peer supports and reported that more than 400 individuals were benefiting from these services in FY 2012. As a result, the State was deemed to be in substantial compliance for this target in 2012, and well on its way to accomplishing the targeted number of clients receiving these services in 2013.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

The State was in substantial compliance for Peer and Family Support Services.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address this issue in this report.

Changes at Delaware Psychiatric Center

While no specific targets were set forth in the Agreement with regard to the performance of DPC, fiscal year 2012 witnessed significant changes in the operation of DPC, all of which are contributing to the accomplishment of targets system wide, including:

- Redefinition of the Acute Care Standards for the Kent 3 Treatment Unit
- Restructuring and reopening the Kent 2 as a second acute care unit
- Development of criteria to convert Sussex 1 from long-term care to a sub-acute treatment unit.
- Reduction in DPC census by over 100 clients from 2009 to present with rare readmissions
- Launching of the new DPC Discharge Policy and Procedure which ensures (1) discharge planning from the day of admission; (2) community provider connection with a client within 48 hours of admission; (3) comprehensive assessment of client needs for timely discharge; and (4) emphasis on independent, integrated living upon discharge with appropriate levels of support
- Discharge of 60 of the original “DPC 75,” the clients with the longest lengths of stay, ranging from 223 to 17,609 days), with only two clients requiring readmission for care within fiscal year 2012
- Working on developing an internal Utilization Review program charged with ensuring that all client admissions are appropriate and that continued stays at DPC are clinically necessary

Quality Assurance and Performance Improvement

The goal of the State’s quality assurance and performance improvement system and activities is to ensure that all mental health services funded by the State are of good quality and sufficient to support individuals in their



pursuit of positive outcomes, including increased integration and independence, self-determination, stable community living, avoidance of harm, and decreased hospitalization and institutionalization. Key system components within this system include the identification and reporting of incidents of harm and death, risk management plans, licensing and Medicaid certification of providers, utilization review, audits of provider contracts and grants, and operation of the Eligibility and Enrollment Unit, which serves as the gatekeeper for clients receiving community services.

The only target set forth for quality assurance and performance improvement in the Agreement was as follows:

If harm occurs . . . , the responsible State, IMD [Institute for Mental Disease—private psychiatric hospital], or community provider will complete a root cause analysis within 10 days. Using the results of the root cause analysis, the State, IMD, or community provider will develop and implement a corrective action to prevent future harm.

Premised upon the State's reporting on incidents of harm in FY 2012, the State was deemed to be in substantial compliance with the Agreement.

Grade by Court Monitor as of Year One – July 1, 2012 – Substantial Compliance

Premised upon the State's reporting on incidents of harm in FY 2012, the State was deemed to be in substantial compliance with the Agreement.

Comments by Court Monitor – March 8, 2013 Report: The Court Monitor did not address Quality Assurance and Performance Improvement in this report.

Over and above the Agreement target, it should be noted that the State has adopted an aggressive quality assurance and performance improvement approach for the new mental health system, including but not limited to:

- Development and maintenance of a risk management plan including training on root cause analysis
- Intensive training of existing staff as well as new staff, including peers
- Annual review of ACT, ICM, CRISP and TCM teams
- Unannounced, full-day visits to providers by the QA team
- Current work to recruit a high-level Performance Improvement Director to oversee system-wide PI efforts

NEXT STEPS

We have come a long way in 18 months, and we still have far to go, but we can be proud of the fact that clients, advocates, peers, providers and state agencies have worked together and made significant progress in reforming Delaware’s mental health services . We will need to continue this collaboration to address subsequent targets, resolve difficult issues that arise during the transitions, and focus on areas in need of strengthening, including but not limited to:

- Integrated information systems among providers, insurers and state agencies;
- A continuum of quality and performance improvement systems;
- Reliance on the care and support of clients in the least restrictive and geographically diverse environments;
- Continuing efforts to provide supported employment services and actual employment to clients living in Delaware’s communities; and
- Continuing modification of the framework established in the first year of the Agreement to move the development of the new mental health system for Delaware forward, as a function of evolving client needs, resources, challenges, and successes.



Notes

1. First Report of the Court Monitor, January 30, 2012, page 1
2. Ibid.
3. Second Report of the Court Monitor on Progress Toward Compliance with the Settlement Agreement: U.S. v. State of Delaware," Robert Bernstein, Ph.D., Court Monitor, September 5, 2012, p. 20.