# FIRST REPORT OF THE COURT MONITOR ON PROGRESS TOWARD COMPLIANCE WITH THE SETTLEMENT AGREEMENT: U.S. v. STATE OF DELAWARE

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

January 30, 2012

## I. Introduction

This is the first report by the Court Monitor ("Monitor") on the implementation of the Settlement Agreement between the U.S. Department of Justice ("DOJ") and the State of Delaware ("the State"). The Settlement Agreement concerns the civil rights of individuals with serious and persistent mental illnesses ("SPMI") who are served in Delaware's public programs. The report presents the Monitor's findings and recommendations relating to the State's progress toward compliance during the six-month period from the date the Settlement Agreement took effect, July 15, 2011.

The Settlement Agreement has tremendous importance for Delaware residents who have mental illnesses, their families, and their communities. When fully implemented, it will result in a significant expansion of community-based services and supports that are crucial to people with SPMI. 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. Consistent with the principles of the Americans with Disabilities Act ("ADA") and the U.S. Supreme Court's *Olmstead* decision, 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 too prevalent today. Accompanying such important human impact, proper implementation of the Settlement Agreement will result in vastly more effective use of public funds that are now heavily invested in responding to mental health crises—including emergency room care and reliance on local police—and in various forms of unnecessary institutional care.

These positive outcomes are more than just aspirations. Delaware is fortunate in that it already has in place many of the components that are required by the Settlement Agreement, and individuals with SPMI who are receiving an appropriate complement of services are now thriving in their communities. The essential problem confronting the State is that these services are not readily available on a scale or with the timeliness that allows a full realization of their benefits. Furthermore, critical services for Delawareans with SPMI have been provided within a bureaucratic context that can fairly be described as challenging and convoluted. The State's

37 current service framework reflects an accumulation of decades of bureaucratic "fixes," and
38 programs that are more structured around reimbursement than effective service delivery. The
39 system is plagued by complex, shifting and sometimes redundant administrative responsibilities
40 that are spread across various departments, divisions and organizations, making it prone to
41 unintended harmful and wasteful consequences. Dispersed oversight responsibilities, combined
42 with the State's siloed data systems challenge attempts at reforms. Furthermore, processes that
43 were designed to address psychiatric emergencies that present an immediate danger to the
44 individual with SPMI or others are often misused, resulting in needless court intervention and
45 institutional confinement of people with SPMI who pose no evident threat. Taken as a whole,
46 these factors not only waste limited public resources, but also have profound civil rights
47 implications; they result in people with SPMI being needlessly segregated in institutions and to
48 being traumatized and degraded, for instance, when handcuffed, taken into custody and
49 transported by police when less intrusive interventions are appropriate. During this initial
50 implementation period, the Monitor has found both a broad awareness that the system is
51 problem-prone and a strong commitment by the State and other stakeholders to achieve the goals
52 of the Settlement Agreement in a meaningful and sustainable way.

53 It is obviously too soon to predict the ultimate success of this endeavor. Stakeholders frequently
54 remind the Monitor that they have witnessed a succession of prior investigations, failed reform
55 efforts, short-sighted decisions and unfulfilled promises relating to Delaware's mental health
56 system. They express genuine interest in the wellbeing of citizens with SPMI, tempered by some
57 skepticism—perhaps, well-founded, given these experiences—as to the ultimate meaning of this
58 newest "fix". Overwhelmingly, their concern is not so much about whether the positive
59 outcomes required by the Settlement Agreement are achievable, but rather whether the effort will
60 be sustained, whether innovation will be encouraged, whether bureaucratic loopholes and
61 challenges will be corrected, and whether the resources needed to allow individuals with SPMI
62 to live and thrive in integrated community settings will remain available over time.

63 This report reflects the State's initial corrective measures in what is envisioned as a five-year
64 process to achieve full compliance. The Settlement Agreement includes few provisions that
65 require completion during this initial six-month period and, as would be expected, Delaware is
66 not yet in full compliance with any of its major requirements. This is not to say that the State is
67 not already making some important strides. The Monitor has found that the leadership of the
68 Department of Health and Social Services ("DHSS") and the Division of Substance Abuse and
69 Mental Health ("DSAMH") have approached implementation with a clear recognition of its
70 importance. They have begun to educate and engage citizens with SPMI, multiple levels of
71 DSAMH staff, providers, advocates and other state agencies with the goal that fulfillment of the
72 ADA—the essential framework of the Settlement Agreement—will become the natural product
73 of the service system.

74 Many of the State's important and innovative activities during this reporting period are critical to
75 addressing these barriers and creating a foundation for lasting improvements, yet they do not

appear as defined milestones in the Settlement Agreement. The Monitor believes that it is important for the Court, the parties, and the general public to be aware of DHSS's and DSAMH's start-up efforts to build infrastructure, examine and correct systemic flaws and to ensure that Delawareans are afforded the Settlement Agreement's full intended benefits. For this reason, this report begins with a discussion of progress on some of these "foundational" issues and then summarizes the status of work with regard to specific provisions. Throughout the report, as applicable, the Monitor makes specific recommendations for immediate action by the State.

The Monitor makes special note of the fact that this Settlement Agreement is being implemented at a time of particular strain on state systems, in Delaware and nationwide. The achievement of compliance requires not just actions on the part of DSAMH, but also of other divisions within DHSS and other departments of State government. Being fully aware that implementation of multiple and far-reaching system reforms is inherently stressful for states—and certainly even more so today—the Monitor acknowledges DHSS Secretary Rita Landgraf 's success in bridging the various governmental divisions that are affected, and in creating an atmosphere that fosters a unified State effort to achieve the goals of the Settlement Agreement. The Monitor commends Secretary Rita Landgraf, Director Kevin Ann Huckshorn, other officials and staff members within Delaware government, as well as to other stakeholders for their insights and assistance, and for their collaborative approach that has enabled the State to make significant progress during this reporting period.

## II. Sources of Information

The findings presented here are based upon a broad set of sources. These include site visits by the Monitor to: Delaware Psychiatric Center ("DPC"), each of the State's Community Continuum of Care Programs ("CCCP"s), each of the three freestanding psychiatric hospitals providing voluntary and involuntary care to people with SPMI (locally and in this report, these are referred to as "IMDs"—Institutions for Mental Diseases), a Crisis and Psychiatric Emergency Service ("CAPES") site, various specialized housing programs for people with SPMI, civil commitment hearings, and advocacy organizations concerned with public mental health services in the State. The Monitor has met with many of the State officials relevant to implementation, and participated in numerous meetings and committees. Examples include meetings with: DSAMH's central community transition team ("Barrier Busters"); leadership of the State's Medicaid office and Medicaid Managed Care Organizations ("MCOs"); the Governor's Mental Health Advisory Committee; DSAMH staff responsible for Quality Assurance, Performance Improvement, and its Eligibility and Enrollment Unit ("EEU"); and workgroups concerned with legislative reforms, data, training, and system reconfiguration. The Monitor has reviewed numerous reports, policies, minutes, inpatient and outpatient case records, data sets and other material relating to implementation. Finally, the Monitor has had regular

formal and informal contact with DHSS Secretary Landgraf, DSAMH Director Huckshorn, DSAMH Deputy Director Smith, other senior Division staff, and representatives from the Office of the Delaware Attorney General. Without exception, the State has provided the Monitor with requested information, facilitated access to any individual with whom the Monitor sought contact, and otherwise offered full and helpful assistance in carrying out the monitoring functions delineated in the Settlement Agreement.

## III. Infrastructure and System Configuration

Before reviewing the State's progress with regard to provisions that are linked to specific achievement dates, this report includes discussion of two critical foundational issues:

- Stakeholders' understanding of measures required by the Settlement Agreement and of the ADA and the *Olmstead* decision which underlie these requirements; and
- Reconfiguration of public systems to comport with the Settlement Agreement, including centralized oversight to ensure that services are least restrictive, most integrating, and meeting the needs of people with SPMI who are served in public programs.

### A. Stakeholders' Understanding of the Settlement Agreement

The Settlement Agreement is explicit in its intent to fulfill the goals of the ADA and related federal laws for Delawareans with SPMI, requiring that public services for people with SPMI be provided in the "most integrating setting appropriate" and 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." (Section I.A) Consistent with this, the Settlement Agreement specifies that "Discharge assessments shall begin with the presumption that with sufficient supports and services, individuals can live in an integrated community setting." (IV.A.1.b) The practical meaning of such integration is plainly expressed: "…people with SPMI can live like the rest of Delawareans, in their own homes, including leased apartments, houses, or living with their family." (II.E.1.a)

Most stakeholders with whom the Monitor has interacted (with the notable exception of mental health consumers, themselves) have indicated that they have read the Settlement Agreement, and many had participated in related local trainings by DSAMH. While this agreement has been promulgated only in the past six months, the federal laws that are its basis have been around for far longer; the ADA was enacted over twenty years ago, and the *Olmstead* decision was rendered over a dozen years ago. Despite the fact that these federal laws have enormous implications for people with SPMI and for how public mental healthcare is delivered, and notwithstanding numerous trainings by DSAMH over the years, the Monitor found a widespread lack of knowledge about the principles of the ADA, their crucial implications for people with SPMI, and how they relate to public services. Senior staff members of DHSS, DSAMH, and the CCCPs have an understanding of the Settlement Agreement and underlying civil rights laws. However, just a step or two below leadership positions, it is apparent that there is often only a passing

155 familiarity with the ADA, the Settlement Agreement, and their requirements. In DPC, the IMDs,
156 and even within civil commitment hearings, the Monitor found practices that do not even
157 minimally reflect ADA considerations. This is particularly significant because it is in these
158 settings, rather than in the offices of management, that decisions about services and interventions
159 for specific individuals are made. Perhaps most poignant is that interactions the Monitor has had
160 with consumers suggest that they are unaware of their own civil rights under the ADA, let alone
161 the fact that the State has effected an agreement with DOJ.
162
163 It is obvious that individuals who are charged with implementing the Settlement Agreement and
164 those who are intended beneficiaries should be well versed in its requirements. It is also
165 important that for the Settlement Agreement to represent something beyond a laundry list of
166 prescribed actions, stakeholders need an appreciation of the underlying values. It is the Monitor's
167 impression that a lack of basic knowledge about the ADA and *Olmstead* has sustained providers,
168 courts and others in unquestioningly making decisions that perpetuate segregation, undermine
169 self-sufficiency, and even result in coercive practices.
170
171 **Recommendation:** To effectively implement the Settlement Agreement and to promote actions
172 that represent the spirit—as well as the specifics—of its provisions, the Monitor recommends
173 that the State immediately launch a multi-pronged training program to ensure that:
174
175 1. The workforce serving individuals with SPMI in publicly funded systems understands
176 and can demonstrate competence in the requirements of the Settlement Agreement and
177 the underlying principles of the ADA and *Olmstead,* and how these relate to daily
178 practice;
179 2. Consumers of services receive training and informational materials that allow them to
180 understand their rights under the ADA and related law and to have current information
181 about the Settlement Agreement, its implementation, and its implications for their lives
182 and life goals; and
183 3. Courts, attorneys, advocates and other parties involved in rights protection and the civil
184 commitment process have a working knowledge of the ADA, *Olmstead* and the goals and
185 requirements of the Settlement Agreement.
186

187 **B. System Reconfiguration**

188 Compliance with the Settlement Agreement will require that the State quickly address structural
189 factors that have sustained unwarranted institutional segregation, confounded proper oversight,
190 and complicated the provision of effective community services and supports. Two key aspects
191 are discussed here; the involuntary commitment statute and oversight of the use of institutional
192 care. Following discussion of these issues are a presentation of measures the State has initiated
193 during this initial implementation period and recommendations by the Monitor for immediate
194 action.

195 1. Civil Commitment:

196 Delaware's civil commitment process does not provide adequate protections, leaving individuals
197 with SPMI vulnerable to unwarranted institutional segregation, coercion, and trauma. Mrs. L,
198 who came to the attention of the Monitor by chance during an impromptu visit to civil
199 commitment hearings, illustrates the scope of this problem. She is particularly interesting
200 because this individual is not what one would consider to be an "outlier." From a clinical
201 perspective, Mrs. L has problems attendant to SPMI that are routinely encountered in public
202 mental health settings. From a service perspective, Mrs. L has not done anything that would
203 generate any sort of special attention, and she is unlikely to do so in the future. In this sense, she
204 is entirely representative of individuals served by Delaware's public mental health system and
205 who are the intended beneficiaries of the Settlement Agreement. Her recent experiences illustrate
206 the manifold problems embedded in the system as currently constructed and that challenge
207 meaningful implementation of the Settlement Agreement.

208 Mrs. L has a long history of psychiatric problems, multiple psychiatric hospitalizations,
209 and service within outpatient mental health settings. She has never harmed herself or
210 anyone else, but has persistent paranoid delusions, for instance, that she is being
211 poisoned. Mrs. L had been living in supportive housing, taking her medications as
212 prescribed and was actively and voluntarily engaged in services at a CCCP. Her
213 outpatient record there indicates that a psychiatrist, nurse and case manager were working
214 closely with Mrs. L, attempting to help her control delusional thoughts and, ultimately, to
215 fulfill her goal of getting a job. Her record shows no significant issues relating to her
216 involvement or compliance with treatment. After appearing uninvited at a relative's
217 house, Mrs. L was brought by police to a hospital emergency department (standard
218 procedure is to transport such individuals in handcuffs), where she was noted to be
219 "sobbing" and expressing strange thoughts. Evidently without consulting her CCCP, she
220 was soon transported—again, by police and handcuffed—to an IMD on a 24-hour hold
221 for involuntary emergency care.

222 Upon admission, the IMD carried out an assessment of Mrs. L. As would be expected,
223 the clinical team found her to be at "Low Risk" of danger to herself and to others.
224 Nevertheless, on the very same sheet that these findings were recorded, Mrs. L's hospital
225 record includes the recommendation for involuntary inpatient psychiatric care, based on
226 her being "psychotic- danger to self and others." She was placed on suicide precautions
227 and monitored by staff at 15-minute intervals around the clock for several days thereafter.

228 At her civil commitment hearing (attended by the Monitor), no evidence was presented
229 indicating that Mrs. L was actually dangerous, nor was there any reference to the fact that
230 she had been actively engaged in voluntary community treatment. The IMD doctor
231 testifying at the hearing recommended that she remain hospitalized for a few more days.
232 Although Mrs. L stated that she would be agreeable to this plan, she was not offered an

233 opportunity to continue her hospital care on a voluntary basis. Instead, she was civilly
234 committed to the IMD. Furthermore, the court ordered that her discharge from the IMD
235 be followed by a period of involuntary outpatient treatment. Upon completion of the
236 hearing, the Monitor inquired as to the rationale and legal basis for ordering involuntary
237 treatment. Neither the attorneys nor the presiding commissioner were able to offer a
238 definitive answer. Mrs. L remained in the hospital for several days thereafter and was
239 referred back the CCCP where she had been treated previously. She was given
240 medications and a copy of her discharge plan, which is perplexing both in its lack of
241 detail and its relevance to Mrs. L's history: "comply with treatment."

242 Certainly, most involuntary psychiatric hospital admissions in Delaware occur in response to
243 situations where there is an immediate danger and where no known viable alternative is available
244 to the crisis responders. As implementation of the Settlement Agreement unfolds, there will be a
245 significantly increased capacity to prevent, intervene early, and avert hospitalization through
246 newly available community alternatives. Nevertheless, Mrs. L's encounters with the emergency
247 system, the police, the court, and the IMD reflect a deeper issue in Delaware. Mrs. L was not
248 dangerous to herself or others and was already receiving a high level of apparently good
249 community services via the CCCP. She was taken into custody, handcuffed and involuntarily
250 committed as an inpatient—and then as an outpatient—not because services were absent, but
251 because factors endemic in Delaware's public systems make involuntary hospitalizations, police
252 transports, and court-ordered outpatient treatment all too common. These actions also did not
253 occur in the absence of oversight; Mrs. L's care in the emergency department and in the IMD
254 was paid for with Medicaid funds that are controlled by a Managed Care Organization ("MCO")
255 operating under contract with the State's Medicaid office. (In the section that follows, the
256 Monitor discusses such oversight in detail, including the differences in outcomes when hospital
257 care is managed by DSAMH.)

258 Many informants have reported to the Monitor that 24-hour emergency psychiatric holds afford a
259 convenient, expedient, reimbursable and poorly-regulated path to removing people with SPMI
260 from where they are not wanted. Busy hospital emergency department evidently use this
261 mechanism not only with people such as Mrs. L, who pose no real threat and whose need for
262 hospital care is dubious, but also for people who actually have substance abuse problems and
263 who express only vague psychiatric complaints. There are few incentives in place that are
264 designed to encourage thoughtful differential diagnosis, to consult with providers currently
265 engaged with an individual or to take the time necessary to construct an appropriate service plan.
266 Instead, a 24-hour emergency psychiatric hold is a simple and readily available alternative, albeit
267 one with serious civil rights implications.

268 The other issue is outpatient commitment following discharge from a hospital. Individuals for
269 whom outpatient treatment is court-ordered are highly vulnerable to re-institutionalization, even
270 for reasons that do not meet civil commitment criteria. They may be returned to a psychiatric
271 hospital by police upon completion of a brief, one-page "Certificate of Non-Amenability," which

272 does not even require a face-to-face examination. Although outpatient commitment is
273 infrequently sought for people being discharged from DPC, people are often released from IMDs
274 with continuing orders for involuntary outpatient treatment. Senior staff members at DSAMH's
275 CCCPs (i.e., the outpatient mental health treatment providers) have indicated that they almost
276 never initiate such court intervention, and that they frequently see instances where there is
277 neither an apparent logic nor a benefit to the use of these intrusive orders. Such outpatient
278 commitment orders conflict with the Settlement Agreement when they are not the least-
279 restrictive, most integrating service appropriate to the individual. To better understand the scale
280 of this issue, the Monitor examined data relating to the prevalence of court-ordered outpatient
281 treatment in Delaware. Neighboring states either do not have statutory provisions for outpatient
282 commitment or use this path only rarely, with individuals who are at particularly high risk. New
283 York is a state where outpatient commitment is used with some regularity and has been intensely
284 studied. Corrected for population, Delaware uses court-ordered outpatient treatment at a rate that
285 is about *ten times* higher than New York.

286 The Settlement Agreement requires that publicly funded mental health services in Delaware be
287 provided in the most integrated, least restrictive manner appropriate to the needs of the
288 individual, and also that services be oriented toward recovery. There are concerns that the State's
289 mental health statute does not appropriately promote these requirements, that hearings relating to
290 involuntary hospitalization and treatment are often perfunctory, and that neither the law nor
291 current practices afford adequate protections against unnecessary institutional segregation.
292 Furthermore, there is a concern that the State's existing civil commitment statute is being used
293 for purposes that were not intended.

294

295 2. <u>Oversight of Psychiatric Hospitalizations</u>:

296 The State's overly-complex arrangements for managing services to people with SPMI poses
297 significant problems in assuring that appropriate interventions are provided, that rights are
298 protected, and that public resources are utilized efficiently. The summary that follows aptly
299 captures the complicated nature of the system that is now in place in Delaware:

300 Inpatient and outpatient mental health treatment for people with SPMI may be funded and
301 regulated by an MCO working under contract with the State's Division of Medicaid and Medical
302 Assistance, by DSAMH's utilization review program (i.e., the EEU), or by both. And based upon
303 whether the individual is eligible for Medicaid benefits, has exhausted those annual benefits, or
304 is determined to have a higher or lower clinical need, the source of payment, the entity with
305 primary oversight responsibility and even the community provider serving the individual may
306 shift. In the latter scenario, individuals in treatment for SPMI are sometimes required to change
307 service providers midstream due to reimbursement, rather than clinical interests. For individuals

308 admitted to IMDs whose Medicaid benefit has been exhausted, DSAMH underwrites the cost of
309 inpatient care, but only if the care is provided on an involuntary basis.

310 This bewildering framework not only challenges consumers and the providers, but it also
311 conflicts with essential civil rights, including those reflected in the Settlement Agreement. For
312 instance, the policy limiting DSAMH funding to civilly committed individuals without insurance
313 was installed to limit the Division's financial liability for inpatient care in IMDs. However, this
314 policy has had the unintended consequence of encouraging involuntary care as a means of
315 guaranteeing payment. Not only is there thus a disincentive for voluntary care, but as is
316 described in the previous section, there are few meaningful protections against misuse of
317 involuntary treatment orders. Furthermore, when there is an involuntary commitment, secure
318 transportation to the hospital by police—that is, in the back of a police car and in handcuffs—
319 presents no reimbursement issues and is readily available whether or not the individual presents a
320 danger and whether or not such physical restraint is detrimental to the individual's overall health.
321 (As an aside, the Monitor notes that the unnecessary reliance on police for transporting people
322 with SPMI also diverts officers from legitimate criminal justice and public safety activities
323 within their communities). DSAMH is aware of this issue and is working to bring about changes
324 that encourage voluntary treatment whenever it is appropriate.

325 In sum, as things now stand, Delaware's protections against unwarranted hospitalization are
326 weak and its complicated funding mechanisms inadvertently incentivize hospital admissions on
327 an involuntary basis. There are additional complications, as well. The State's mental health
328 authority, DSAMH, does not have consistent control over publicly funded services to people
329 with SPMI who are currently eligible for Medicaid benefits. In fact, currently DSAMH may
330 know very little, if anything, about inpatient or outpatient services provided to individuals with
331 SPMI under the Medicaid program.

332 For certain publicly funded individuals who are involuntarily admitted to psychiatric hospitals,
333 DSAMH's EEU plays an important and informative role. When an inpatient episode is being
334 paid for with DSAMH funds—that is, when individuals have no insurance or when Medicaid or
335 other insurance coverage is exhausted—DSAMH's EEU determines the need for inpatient
336 services and oversees reimbursement for hospital care accordingly. When individuals have
337 Medicaid coverage for care in an IMD (as was the case with Mrs. L), an MCO that is under
338 contract with the Division of Medicaid and Medical Assistance manages the care instead; the
339 EEU plays a limited role in ensuring that the legal filings are in order and, as needed, in referring
340 the individual to an inpatient facility. In short, DSAMH currently has no meaningful authority to
341 control inpatient admissions to IMDs for people with SPMI who are covered by Medicaid.

342 Clinically, there is no reason to expect that the populations with and without active Medicaid
343 coverage are different in any way. Furthermore, referrals to the three IMDs are made on the basis
344 of bed availability and other factors that would not differentiate them in terms of clinical issues
345 or distinguish them from the population receiving acute care at DPC. Yet, the Monitor's review

346 of data relating to over 3,000 involuntary admissions (covering the period 7-1-10 through 10-31-
347 11) and a sample of case records shows some striking trends:

348 • The average length of hospital stay in IMDs was 15% longer when care was managed
349 by an MCO, as compared with care managed by DSAMH.

350 • Longer average lengths of stay under Medicaid MCO management occurred in each of
351 the IMDs, as compared with DSAMH management, whether or not co-occurring
352 substance abuse disorders were identified.

353 • There are a number of admissions to DPC—and as one would expect, also to the
354 IMDs—of individuals who have primary problems of substance abuse and sometimes
355 only vague symptoms that would justify court-ordered psychiatric hospitalization.
356 Within DPC, these admissions are generally converted to voluntary status and
357 individuals are discharged soon thereafter. Some of these individuals are released to
358 detox centers. Others want to be immediately released, and go to shelters because
359 appropriate housing cannot be arranged on short notice. In many instances, the
360 likelihood of readmission is very high. For instance, in the six months since the
361 Settlement Agreement has been in effect, one individual reviewed by the Monitor
362 accumulated six hospital admissions, four to DPC and two to IMDs

363 • Co-occurring substance abuse is diagnosed in roughly *half* of the admissions to DPC
364 and in two of the IMDs. The third IMD identifies substance abuse issues in only 12% of
365 its admissions. At a minimum, this suggests that diagnostic practices afforded people
366 with SPMI in public programs are not standard. Some informants have reported to the
367 Monitor that co-existing substance abuse diagnoses might raise questions as to the
368 appropriateness of a psychiatric admission, legally and in terms of reimbursement. To
369 the extent that this is true, this might affect the accuracy or completeness of diagnoses
370 that are recorded in the hospital record.

371 • Without question, psychiatric inpatient stays should be as brief as possible. Yet,
372 involuntary hospitalizations (i.e., admissions that ostensibly involve an immediate
373 danger to self or others) lasting one or two days raise questions as to whether the
374 admission was appropriate in the first place. On DPC's acute care unit (K-3), these
375 occurred in about 12% of the admissions, sometimes in regard to individuals who
376 actually have substance abuse problems, rather than SPMI, and who nevertheless were
377 admitted on 24-hour psychiatric holds. In the IMDs, these discharges occur far less
378 frequently, in only 5% of the admissions. Possibly accounting for part of this difference
379 is the reported latitude afforded by Medicaid MCOs in routinely approving five-day
380 admissions to IMDs. There is presently no system in place to flag instances where
381 admissions appear to be questionable, to identify the systemic factors that culminated in
382 inappropriate admissions, or to account for these and other differences in publicly
383 funded involuntary hospital care. Further, the Monitor could access no hard data on the
384 cost to the public system relating to these problematic hospitalizations.

385 The essential issues raised by this review of the data are whether involuntary psychiatric
386 hospitalization is appropriate in the first place, whether 24-hour holds are being misused, and
387 whether core service needs are being appropriately addressed.

The Monitor found no evident clinical explanation for these variations among the IMDs, between the IMDs and DPC's acute care unit, and between hospital care that is reimbursed through Medicaid as opposed to DSAMH funding. These differences, which have important implications for the civil rights of individuals with SPMI and for the State's compliance with the Settlement Agreement, are attributable to the currently convoluted bureaucratic structure though which services are managed and to gaps in essential legal protections. There are also obvious fiscal implications associated with questionable hospital stays.

3. Measures Being Taken by the State:

The Monitor has found broad agreement that issues relating to civil commitment and the oversight of publicly funded inpatient care of individuals with SPMI need to be addressed in order to achieve compliance with the Settlement Agreement and to ensure that the expansion of services has its intended impact. During the initial six months of implementation, DSAMH and the Monitor have been working closely on several measures:

- DSAMH has completed an excellent root-cause analysis of the diverse factors contributing to the questionable hospital admissions of individuals such as Mrs. L, and has identified aspects of the mental health statute and the healthcare delivery system that contribute to this problem. Based in part on these findings, the State is currently evaluating how protections against unwarranted institutional confinement can be strengthened and how the full benefits of pre-screening and diversion programs (for example, the Mobile Crisis Services and case management discussed later in this report) can be realized through refinements in the legal and regulatory framework.
- A group of senior DSAMH staff members is working on a system map that lays out how public mental health services might be simplified and better aligned to ensure the requirements of the Settlement Agreement. An important overarching goal is establishing more consistent oversight so that appropriate publicly funded services are available to all individuals with SPMI—regardless of insurance status, legal status, or place of residence within Delaware. Furthermore, the system map being developed is intended to make far better use of data to ensure quality and efficiency, and to drive improvements in the public system. Without question, the group's current ideas about reconfiguration will come to be refined over the implementation period and beyond. But this effort is pivotal in that, from the outset, it is encouraging implementation measures to proceed within the context of a bigger picture, one that is more coherent than the status quo.
- DSAMH has provided the Monitor with some preliminary data that may begin to identify instances where individuals with substance abuse disorders and other issues not specifically related to SPMI are being inappropriately admitted to psychiatric beds. The intent is to explore the reasons for this occurring and to identify needed improvements in oversight and community based alternatives to hospital care.

DHSS Secretary Landgraf and DSAMH Director Huckshorn have been actively engaged in evaluating these systemic problems, which appear to be the culmination of decades of narrow

428 or shortsighted policymaking. Moving forward, their plan is to promote some critically
429 needed changes in the structure of services for people with SPMI, the oversight of these
430 services, and processes to safeguard the rights of individuals served in public mental health
431 programs.

432

433 **Recommendations:**

434 These efforts by the State are commendable because, in the Monitor's opinion, they contribute to
435 the establishment of a solid foundation for sustainable reforms and continuous improvement
436 during and beyond the Settlement Agreement. Instead of attempting to embed the Settlement
437 Agreement requirements within current practices, they reflect an openness by DHSS and
438 DSAMH to attacking what have been some longstanding operational challenges. As of this
439 writing, these initiatives represent works in progress, but there are some actions that the Monitor
440 strongly recommends be pursued in the immediate term:

441 1. The State should move as quickly as possible to introduce a comprehensive set of
442 reforms—programmatic, administrative and legal—that will reduce the unwarranted
443 institutionalization of Delawareans with SPMI and will make far better use of public
444 resources that are now invested in late-stage interventions and preventable hospital care.
445 There is an urgent need to introduce these reforms, above all to uphold the essential civil
446 rights of individuals with SPMI who are served by public systems. Beyond this, it is also
447 critical that the new and expanded programs that are being phased in per the Settlement
448 Agreement are embedded in a coherent, accountable system that is clearly oriented
449 toward recovery and community integration.

450 2. As is feasible within the context of the existing mental health statute, the State should
451 immediately provide guidance to the Courts, attorneys representing the State in
452 commitment actions, and other advocates requiring that petitions for civil commitment—
453 whether inpatient or outpatient—and 24-hour holds be supported by specific information
454 relating to the presence of a serious mental illness, imminent danger to self or others, and
455 the absence of less restrictive alternatives.

456 3. The EEU should be expanded and established as the statewide vehicle for managing
457 publicly funded inpatient and outpatient services for all Delawareans with SPMI, and
458 regardless of whether services are funded through DSAMH, Medicaid or another public
459 program. Centralizing oversight in this way will:

460 a. Allow a straightforward, understandable, consistent and accountable process for
461 ensuring that the full array of services and supports is available to all individuals
462 with SPMI according to individual needs;

463 b. Allow creation of a central data base to track the utilization, effectiveness and
464 changing needs relating to the services and supports that will fulfill the
465 requirements of the Settlement Agreement;

466 c. Position the State to make far more informed projections as to future service
467 needs, particularly with regard to housing, emergency services and early
468 intervention;

d. Improve management of the various public resources allocated for services to Delawareans with SPMI by reducing expenditures for unnecessary hospitalizations and other high-end services and enabling a better understanding of the impact of investments in timely, effective community services; and

e. Significantly improve monitoring to ensure that individuals with SPMI are being served in the least-restrictive, most integrated settings appropriate to their needs.

4. When hospital treatment is indicated, DSAMH should encourage that this be carried out on a voluntary basis and should no longer restrict payment only to involuntary admissions. This measure should be accompanied by enhanced oversight by the EEU to ensure that hospital admissions are appropriate and that lengths-of-stays are clinically justified.

5. The State should immediately fund DSAMH's needs to staff positions within the EEU. As the EEU assumes broader responsibilities in utilization management, the need for further expansion of the EEU to fulfill the requirements of the Settlement Agreement should be examined periodically. The State's most recent report to the Monitor on this issue is the same as it has been for some time already, that approval of these positions is "in process." For all of the reasons detailed above, the Monitor strongly recommends that needed EEU positions be filled without delay.

6. The State should immediately expand the EEU's oversight to include ongoing on-site reviews at DPC and the IMDs. Not only will such oversight further the State's compliance with the Settlement Agreement, but it will also better ensure that unnecessary inpatient expenses are not incurred. Although this may require further expansions in the level of EEU staffing, it is probable that the efficiencies achieved through improved monitoring will substantially offset additional costs.

7. In collaboration with the Monitor, the State should immediately begin analyses of inappropriate admissions to DPC and the IMDs. To further this effort, DSAMH should instruct hospitals to flag admissions where the need for inpatient psychiatric care is questionable.

8. In collaboration with the Monitor, the State should initiate a study of hospital emergency departments and how they deal with individuals who have substance abuse disorders and who do not have justifiable co-existing diagnoses of SPMI. The focus should be on developing a system of care that appropriately addresses their needs and that rectifies the current misuse of public psychiatric beds.

9. The State should quickly expand its mobile crisis capacity statewide and make this service available to hospital emergency departments to provide assessments and referrals as an alternative to the 24-hour emergency holds resulting in psychiatric inpatient admissions. DSAMH recently informed the Monitor that additional positions for mobile crisis services have been approved. The Division should make it a priority to fill these positions and expand this critically important service.

510 **<u>IV. Progress On Specific Provisions</u>**

511 **A. Explanation of Ratings**

512 In this section, the Monitor presents brief summaries of the State's progress to fulfill specific
513 provisions of the Settlement Agreement, particularly those with defined target dates. While few
514 of the Settlement Agreement's target dates actually fall within the start-up period covered by this
515 report, there are many instances where the State has begun phase-ins or is otherwise taking
516 preparatory measures in anticipation of meeting goals that are set for the year 2012.

517 For each goal with a target date that falls within this reporting period, the Monitor has made a
518 determination as to whether the State is in "Substantial Compliance," "Partial Compliance," or
519 "Noncompliance" (Section VI.B.3.g defines these ratings.). Four of the provisions discussed in
520 this report (III.I.1, IV.B1, IV.B.2 & IV.B.3) relate to discrete, one-time activities to be completed
521 within this period and that have the potential for achieving "Substantial Compliance." Other
522 activities reflect what will be ongoing processes or interim steps toward long-range goals. For
523 these, a rating of "Substantial Compliance" cannot yet be achieved; a rating of "Partial
524 Compliance" may indicate that the State is making the progress that is attainable at this stage.

525

526 **B. Evaluations of Compliance**

527

528 1. <u>Provisions with Target Dates in This Reporting Period</u>:

529 The following four provisions have target dates for activities that were to be accomplished within
530 the initial six-month implantation period:

531

532 III.A.1 *Crisis Hotline: By January 1, 2012 the State will develop and make available a crisis*
533 *line for use 24 hours per day, 7 days per week.*

534 **<u>Substantial Compliance</u>.** The Crisis Hotline is in place and is operational around the clock. The
535 Monitor has tested the Hotline on several occasions at different times of day; the call was
536 promptly answered each time.

537

538 IV.B.1 *Implementation of Transition Assessments and Placement: Within 30 days of the*
539 *signing of the agreement the State will re-assess all individuals currently in*
540 *institutional settings.*

541 **Partial Compliance.** During this reporting period, the State has concentrated on the
542 approximately 75 individuals in DPC—most of whom with long institutional histories—who
543 have been identified as appropriate for discharge to community settings. These individuals tend
544 to have complex psychiatric and medical issues that have heretofore been seen as barriers to
545 discharge. Virtually all of them are in need of housing and ongoing intensive supports. These
546 individuals have been reassessed by DPC and community providers, consistent with the
547 Settlement Agreement and with consideration of how enhanced community services can promote
548 integration. Progress and barriers relating to the discharge of these individuals, and deliberations
549 about how integrated living arrangements can be achieved, are occurring through the central
550 specialized transition team, "Barrier Busters." (see IV.B.3).

551 The Monitor has also found that assessments and discharges of other clients at DPC, including
552 individuals being treated on the acute care units, are not adequately reflective of the requirements
553 of the Settlement Agreement. Based on a review of records, discharge data and meetings with
554 staff members, practices appear to be pretty much "business as usual" and do not include the
555 analyses discussed above. A surprising number of individuals have continued to be identified as
556 appropriate for group homes or even shelters without an evident evaluation of what services and
557 supports could make more stable, integrated living arrangements viable.

558 Similarly, assessments of individuals with SPMI who are in IMDs are apparently occurring as
559 they had been, without obvious changes attendant to the requirements of the Settlement
560 Agreement. Presently, DSAMH has little oversight responsibility in these settings. If the State is
561 to ensure that all individuals with SPMI served in IMDs receive appropriate assessments and
562 benefits per the Settlement Agreement, it will be necessary for the State to centralize
563 responsibility, as is discussed above in Section II.

564 Two important factors justify a finding of "Partial Compliance:"

565 • Assessments that are consistent with the requirements of the Settlement Agreement
566 constitute a significant culture change among hospital staff and community providers.
567 Members of the "Barrier Busters" transition teams are demonstrating palpable changes in
568 the right direction. Community providers are working closely with individuals who are
569 receiving long-term care at DPC, and at Barrier Busters meetings hospital staff and
570 community providers engage in regular—sometimes spirited—discussions of assessed
571 needs and how challenges to integrated community living can be overcome. Though still
572 evolving, these teams represent a significant positive accomplishment in evaluating
573 individuals with SPMI and devising plans for community living.

574 • There is no standard instrument that the State can turn to as a protocol for assessing
575 individuals with SPMI that (as required by the Settlement Agreement) is grounded in
576 assumption that individuals can live in integrated settings if sufficient supports and
577 services are made available. Most existing models are clinically-oriented or do not
578 culminate in a specific list of services and supports that can promote integration. In the
579 Monitor's early discussions of this issue with DSAMH leadership, it became apparent

580 that such an assessment tool could structure thinking by hospital and community
581 providers and help cultivate the new approaches to evaluation and services that are
582 required to achieve compliance. Furthermore, such an assessment tool could be designed
583 to facilitate appraisals of the impact of services, quality monitoring and an understanding
584 of unmet service needs on individual and aggregate levels. DSAMH has moved forward
585 with this idea, engaging consumers and community providers to draft the "Delaware
586 Uniform Assessment." Consistent with the requirements of the Settlement Agreement,
587 this tool is person-centered and seeks to identify the specific day-to-day supports—
588 conventional and otherwise—that will enable the individual to live in an integrated
589 setting of his/her choice. Tentatively, DSAMH intends is to pilot this instrument within
590 DPC early in 2012 and, with refinements, to roll it out to other settings.

591 The Monitor considers these to be very important accomplishments.

592 **Recommendations:**

593 1. In consultation with the Monitor, DSAMH should immediately develop a process
594 whereby any individual who is hospitalized in DPC and whose team recommends
595 a discharge disposition *other* than supported housing (as defined in the Settlement
596 Agreement) or independent living undergoes an administrative review. This
597 process should be implemented immediately upon being finalized.

598 2. Within 60 days of implanting the above recommendation, the State should
599 implement a parallel process, whereby it reviews all instances where inpatients of
600 IMDs with public funding are being considered for discharge to a non-integrated
601 setting.

602 3. DSAMH should proceed as planned to pilot its assessment protocol within DPC,
603 and should develop a timetable to evaluate the utility of this instrument and to
604 apply it system-wide.

605

606 IV.B.2. *Within 60 days of the signing of the agreement the State will make operational*
607 *transition teams including community provider and peer representatives.*

608 **Partial Compliance.** As is discussed immediately above, transition teams are operational with
609 regard to the population targeted by Barrier Busters. Elsewhere in DPC, there is at least a
610 nominal assignment of a community representative for each individual, in some instances a
611 Targeted Case Manager ("TCM"). As things now stand, there is a lack of appropriate oversight
612 to ensure that all individuals are assigned a community representative in a timely way or that the
613 community representative participates in team meetings. In some instances, clients at DPC have
614 co-occurring developmental or intellectual disabilities. The Monitor has learned that
615 participation in transition planning by representatives of the State's Division of Developmental
616 Disability Services ("DDDS") has been a chronic problem for such individuals. Furthermore,
617 depending upon where an individual lives in the state, the assigned TCM may, or may not, be
618 involved in the provision of services post-discharge. As TCM is brought to scale statewide, it is
619 anticipated that the latter issue will be addressed.

620 In IMDs, there is sometimes involvement by a community provider in discharge planning,
621 depending upon whether an individual is active with a CCCP and whether efforts are made to
622 include the provider in treatment planning. Implementation of DSAMH's plans for statewide
623 TCM should bring about improvements, but currently there is no mechanism for oversight.
624 Further, there are other issues that speak to the need for the centralized management process and
625 oversight by DSAMH's EEU, discussed above (e.g., as things now stand, DSAMH does not even
626 know of voluntary admissions to IMDs that are being covered by Medicaid).

627 **Recommendation:** DSAMH should immediately begin random reviews of individuals within
628 DPC and the IMDs to assure that transition teams are operational per the requirements of the
629 Settlement Agreement. Data from these reviews should inform training needs and the
630 development of a single oversight process relating to all publicly funded admissions.

631

632 IV.B.3. *Within 60 days of the signing of the agreement the State will make operational a*
633 *central specialized transition team including community provider and peer*
634 *representatives.*

635 **Partial Compliance.** As is discussed above, Barrier Busters is the centralized transition team.
636 Meetings occur weekly, alternating between providers in the northern and southern areas of the
637 state. Participants include representatives from the CCCPs, DPC administrative and clinical staff,
638 and consumers.

639

640

641 2. Provisions With Upcoming Target Dates or Without Fixed Target Dates:

642 The provisions discussed below either have target dates for achievement during the coming six-
643 month review period (generally, July 1, 2012) or else reflect requirements that are not associated
644 with fixed target dates, but that have significant activities to be reported. Where a compliance
645 rating is applicable, the highest possible rating that can be attained at this point is "Partial
646 Compliance."

647 II.B.1-2 Target Population: The Settlement Agreement requires the development of a
648 "Target Population List," as follows:

649 *1. The target population for the community services described in this section*
650 *is the subset of the individuals who have serious and persistent mental illness*
651 *(SPMI) who are at the highest risk of unnecessary institutionalization. SPMI is a*
652 *diagnosable mental, behavioral, or emotional disorder of sufficient duration to*
653 *meet diagnostic criteria and has been manifest in the last year, has resulted in*

654 *functional impairment which substantially interferes with or limits one or more*
655 *major life activities, and has episodic, recurrent, or persistent features.*

656 *2. Priority for receipt of services will be given to the following individuals*
657 *within the target population due to their high risk of unnecessary*
658 *institutionalization:*

659 *a. People who are currently at Delaware Psychiatric Center, including those on*
660 *forensic status for whom the relevant court approves community placement;*

661 *b. People who have been discharged from Delaware Psychiatric Center within*
662 *the last two years and who meet any of the criteria below;*

663 *c. People who are, or have been, admitted to private institutions for mental*
664 *disease ("IMDs") in the last two years;*

665 *d. People with SPMI who have had an emergency room visit in the last year, due*
666 *to mental illness or substance abuse;*

667 *e. People with SPMI who have been arrested, incarcerated, or had other*
668 *encounters with the criminal justice system in the last year due to conduct*
669 *related to their serious mental illness; or*

670 *f. People with SPMI who have been homeless for one full year or have had four*
671 *or more episodes of homelessness in the last three years*

672 **Partial Compliance.** Key to meaningfully implementing virtually all of the provisions of the
673 Settlement Agreement is information based on the size, composition and needs of the Target
674 Population. DSAMH has some significant challenges associated with its internal data systems,
675 but through its EEU and other vehicles, it has ready access to information about individuals
676 within or discharged from DPC (II.B.2.a-b) and the subset of individuals treated in IMDs with
677 DSAMH funding if they were admitted involuntarily (II.B.2.c). Information relating to
678 individuals with SPMI who were admitted to IMDs on a voluntarily basis and whose care was
679 covered by Medicaid or Medicare has not been regularly accessible by DSAMH. Likewise,
680 information relating to people with SPMI seen in emergency rooms (II.B.2.d), involved with
681 criminal justice (II.B.2.e), or who are homeless (II.B.2.f) has not generally been available to
682 DSAMH unless there has been a specific referral for services.

683 As is the case nationwide, electronic information within Delaware's various public systems is
684 siloed and not formatted in a way that permits interdepartmental sharing or easy consolidation
685 into the Targeted Population List required in the Settlement Agreement. The State has launched a
686 cross-department information sharing initiative relating to reentry from criminal justice ("I-
687 ADAPT"), which may ultimately provide a format for monitoring service plans across systems.
688 To meet the immediate requirements of the Settlement Agreement, DSAMH has had to find
689 innovative means of accessing information from other state systems while at the same time
690 preserving the confidentiality of the people it serves. This has been a bureaucratically daunting
691 task, but the Division's success during its first six months of implementing this Settlement
692 Agreement is impressive, and may be instructive for *Olmstead* activities in other localities.

693 DSAMH has negotiated access to the State's homelessness data base, the Homelessness
694 Management Information System ("HMIS") and to the Delaware Criminal Justice Information
695 System ("DELJIS"), which has timely data relating to arrest and incarceration. In both instances,
696 the Division is positioning itself to be able to gather information about individuals known to
697 have serious mental illnesses by providers in other State's bureaucracies. Further, DSAMH will
698 be able to determine if individuals it is already serving meet additional criteria for prioritization
699 under the Settlement Agreement under paragraphs II.B.2.e or II.B.2.f. To secure information
700 about voluntary publicly funded admissions to IMDs and emergency room visits, DSAMH has
701 been working with the State's Medicaid agency to run relevant encounter data against a listing of
702 diagnostic codes reflecting SPMI.

703 While the elements of Target Population List are not yet fully in place, during this initial
704 implementation period DSAMH has done a commendable job of navigating bureaucratic hurdles
705 to create an integrated database that will meet the requirements of the Settlement Agreement and
706 guide service delivery and planning. As was referenced in the Introduction section, DSAMH and
707 DHSS have achieved this during a period when state systems as a whole are already under stress
708 and when requests for new information and participation in additional meetings (relating to the
709 Settlement Agreement) may be particularly challenging. Nevertheless, as of this writing, the
710 State's concerted effort has resulted in the identification of approximately 5,000 Delawareans
711 who meet priority criteria. This information has been consolidated into a single database of
712 unduplicated names. To test the validity of the list, the Monitor gathered names of individuals
713 that providers knew to be homeless or treated in hospital emergency rooms for mental health
714 crises. The Monitor spot-checked a subset against the State's Targeted Population List; in all
715 instances examined, these names appeared on the State's list.

716

717 III.B.1 *Mobile Crisis Services: By July 1, 2012 the State will make operational a sufficient*
718 *number of mobile crisis teams such that a team responds to a person in crisis*
719 *anywhere in the state within one hour.*

720 **Partial Compliance**. Mobile Crisis Services are now operational in the northern part of
721 Delaware and are working effectively, given current capacities. DSAMH has defined additional
722 staffing and personnel changes that will be required to achieve compliance with this provision
723 and is preparing to extend these services statewide. DSAMH is planning to establish data
724 protocols that will enable it to monitor whether the response time of Mobile Crisis Services is
725 consistent with the one-hour standard and, as may be applicable, to make program adjustments
726 accordingly. Within the coming six months, DSAMH will need to ensure that there is a one-hour
727 maximum Mobile Crisis response statewide.

728 **Recommendation:** The Monitor believes that DSAMH has the capacity to rapidly bring its
729 Mobile Crisis Services to scale once staffing positions are approved. These services are not only

730 critical to address mental health emergencies, but as is discussed elsewhere in this report, can
731 also play a key and urgently needed role in preadmission screening and diversion within hospital
732 emergency departments. For these reasons, the Monitor strongly recommends that the State
733 accelerate measures to implement this provision.

734

735 III.C.1 *Crisis Walk-in Centers: In addition to the crisis walk-in center in New Castle County*
736 *serving the northern region of the State, by July 1, 2012, the State will make best*
737 *efforts to make operational one crisis walk-in center in Ellendale to serve the southern*
738 *region of the State. The crisis center in Ellendale shall be operational no later than*
739 *September 1, 2012.*

740 **Partial Compliance**. The Monitor has had an opportunity to visit the one operational Crisis
741 Walk-in Center, "CAPES" in New Castle County, to interview several informants about the
742 nature and effectiveness of this program, and to review data and case records that are reflective
743 of their impact. By all accounts, this is an effective service model and an important community
744 resource that represents collaboration in direct services by DSAMH staff with private providers
745 that operate under contract with the Division. Based on the State's activities with respect to this
746 provision, it is anticipated that the required expansion to the southern regions of Delaware will
747 be met by the target date. Renovations of the Ellendale facility are underway and expected to be
748 completed by June, 2012. DSAMH is now in the process of developing a Request for Proposals
749 ("RFP") that will allow this additional crisis walk-in center to be operational by September.
750 Efforts to develop a crisis center in the southern part of the State appear to be moving along well.

751

752 III.D.1 *Crisis Stabilization Services By July 1, 2012 the State will ensure that an intensive*
753 *services provider meets with every individual receiving acute inpatient crisis*
754 *stabilization services within 24 hours of admission in order to facilitate return to the*
755 *community with the necessary supports and that all transition planning is completed in*
756 *accordance with Section IV.*

757 **Partial Compliance**. The system reconfigurations that are now being formulated by DSAMH
758 are contemplating this requirement, in part, by immediately assigning individuals a Targeted
759 Case Manager ("TCM") upon entry into the crisis system, regardless of diagnosis. When
760 individuals in crisis are already receiving services, the provider will be immediately contacted
761 and expected to make timely face-to-face contact. Also planned is periodic and consistent
762 oversight by the EEU for individuals whose care is managed by DSAMH; for other individuals
763 with SPMI who are eligible for public services (e.g., via Medicaid), the expanded role of the
764 EEU that is discussed above would provide linkages to needed services, including the expanded
765 services required by the Settlement Agreement. In the immediate term, DSAMH is focusing on
766 DPC, working to ensure that individuals who are admitted to the facility for acute care are linked

767 to either a TCM or, as applicable, a representative of their CCCP. There are several
768 administrative challenges to achieving this goal within DPC, and the DSAMH Director is
769 currently working with the facility's new CEO to address these. Because of the complexities of
770 the existing service structure, compliance with this provision and appropriate monitoring will be
771 far more difficult in the IMDs unless, as recommended above, DSAMH assumes the overall
772 management of all individuals with SPMI receiving publicly-funded services. This is an interim
773 evaluation of progress with respect to this provision; the Monitor will evaluate the State's status
774 more completely in the one-year report, at which point the Settlement Agreement requires
775 system-wide compliance.

776 **Recommendation:** To achieve compliance with this provision and to address other issues raised
777 in this report, it is essential that the State consolidate its management of publicly funded
778 psychiatric hospital care, as recommended in Section III of this report

779

780 III.E.1 *Crisis Apartments: By July 1, 2012 the State will make operational two crisis*
781 *apartments.*

782 **Partial Compliance.** Two crisis apartments are already operational in New Castle County. The
783 Monitor plans to visit and evaluate this program during the next review period, at which point
784 the implementation target date will have been reached.

785

786 III.F.1 *Assertive Community Treatment: By July 1, 2012 the State will expand its 8 ACT*
787 *teams to bring them into fidelity with the Dartmouth model.*

788 **Partial Compliance.** In December, 2011, DSAMH issued an RFP for Assertive Community
789 Treatment ("ACT") and Intensive Case Management Services. Contracts awarded in response to
790 this RFP will replace agreements currently in effect with CCCPs and will enhance staffing ratios
791 to comport with the Dartmouth model. The RFP envisions that DSAMH will award contracts for
792 ACT in March, 2012, with projects beginning operations during the period April 1 to July 1,
793 2012.

794

795 **Comment**: The timely issuance of this and other RFPs referenced in this report is critical to
796 fulfilling the specific requirements of the Settlement Agreement and achieving its important
797 objectives. The Monitor notes that crafting and vetting RFPs for public mental health services is
798 generally a very arduous, protracted endeavor. The quality of the RFPs that have been
799 developed, as well as DHSS's success in expediting bureaucratic processes, affirm the State's
800 commitment to developing an effective community system to support Delawareans with SPMI.

801

802 III.G.1 *Intensive Case Management: By July 1, 2012 the State will develop and begin to*
803 *utilize 3 ICM teams.*

804 **Partial Compliance.** The RFP referenced in regard to III.F.1 includes the development of three
805 fidelity-based Intensive Case Management teams, with the same schedule for implementation.
806 Intensive case management will reflect a new service model in the State and may reflect new
807 providers. The Monitor's one-year review will report on the operations of the ICM teams.

808

809 III.H.1 *Case Management: By July 1, 2012 the State will train and begin to utilize 15 case*
810 *managers.*

811 **Partial Compliance.** DSAMH has developed parameters for a new statewide TCM program that
812 is intended to fulfill the requirements of this provision. To ensure that TCM embodies the
813 independence needed to effectively monitor and advocate on behalf of its clients, DSAMH is
814 limiting applicants for this initiative to organizations that do not provide direct client services
815 under other contracts with the Division. The RFP for TCM is expected to be issued by February
816 10, 2012 with implementation to begin in May, 2012. The Monitor will provide a more
817 complete report on the State's progress with respect to this provision in the one-year report.

818

819 III.I.1 *Supported Housing: By July 11, 2011, the State will provide housing vouchers or*
820 *subsidies and bridge funding to 150 individuals. Pursuant to Part II.E.2.d., this*
821 *housing shall be exempt from the scattered-site requirement*

822 **Partial Compliance.** DSAMH has provided the Monitor with a list of 150 individuals who are
823 currently living in supported housing funded through housing vouchers or DSAMH. Individuals
824 living in these settings receive clinical and other needed community services through CCCPs.
825 The Monitor randomly selected and visited 9 individuals from this list, who are living in three
826 different supported housing venues in New Castle County. These individuals all have SPMI,
827 some with co-occurring disabilities (e.g., one individual is blind and another has an intellectual
828 disability). Two of the sites are what would be considered "ordinary" living arrangements, that
829 is, garden apartment complexes with most units occupied by average individuals and their
830 families. In these sites, supported housing units for people with SPMI are mostly clustered
831 together, with each apartment generally housing two individuals who have their own bedrooms.
832 Housemates are assigned by the CCCP, which has an office on the premises. The third site is a
833 newly remodeled building that was converted specifically to provide supported housing. It has
834 single occupancy units. Many of the residences visited by the Monitor—particularly in the
835 garden apartments—were personalized and the occupants' hobbies and interests were

836 immediately evident. Most individuals cook their own meals (some admitted to occasionally
837 getting carryout food).

838 In summary, the supported housing visited by the Monitor affirms that there already are
839 programs in Delaware enabling individuals with significant psychiatric disabilities to live in
840 semi-integrated housing and often to assume substantial responsibility for tasks of daily living.
841 These site visits affirmed for the Monitor that the development of the more fully integrated
842 housing required by Settlement Agreement should be readily achievable.

843

844 III.I.2. *By July 1, 2012 the State will provide housing vouchers or subsidies and bridge*
845 *funding to a total of 250 individuals.*

846 **Partial Compliance.** This provision requires the development of new scattered-site supported
847 housing for 100 additional individuals with SPMI by the target date. At this point, DSAMH has
848 funding that will support development of integrated housing for 25 individuals, plus housing
849 vouchers have been earmarked for an additional 25 individuals. The State will need to make
850 funding available for an additional 50 individuals to meet this provision's requirements.
851 Supported housing that comports with the Settlement Agreement is beginning to be developed,
852 particularly for individuals now at DPC. As it happened, one such individual who had been an
853 inpatient at DPC is now living with supports from the CCCP in her own apartment in one of the
854 complexes discussed in the above section. She lives in a different building within this sprawling
855 development and CCCP staff was very mindful of the fact that this was in compliance with the
856 Settlement Agreement's definition of what constitutes scattered-site, integrated housing
857 (II.E.2.g). The Monitor noted good news on two fronts regarding this individual and the State's
858 start-up efforts relating to this provision: she was reported to be doing "beautifully" in her own
859 apartment, and the Monitor was not be able to meet with her because she was out visiting her
860 family. Ostensibly, she is leading the "ordinary" life envisioned by the Settlement Agreement for
861 Delawareans with SPMI.

862 **Recommendation:** The State will need to secure funding for housing an additional 50
863 individuals by July 1, 2012, and will need to make longer-range provisions to assure
864 achievement of the incremental goals throughout the life of the Settlement Agreement.

865

866 III.J.1 *By July 1, 2012 the State will provide supported employment to 100 individuals per*
867 *year.*

868 **Not Rated.** Supported employment is a part of CCCP contracts, but the Monitor has not yet
869 reviewed the State's compliance with this provision. Compliance with this provision will be
870 evaluated in the next report.

871

872 III.K.1 *By July 1, 2012 the State will provide rehabilitation services to 100 individuals per*
873 *year.*

874 **Not Rated.** The Monitor has not yet reviewed the State's compliance with this provision; the
875 next report will address this provision.

876

877 III.L.1 *By July 1, 2012 the State will provide family or peer supports to 250 individuals per*
878 *year.*

879 **Not Rated.** The Monitor has not yet reviewed the State's compliance with this provision; it will
880 be addressed in the next report.

881

882 IV.B.5 *By July 1, 2012 the State shall develop a program to educate judges and law*
883 *enforcement about community supports and services for individuals with mental*
884 *illness on forensic status.*

885 **Not Rated.** The Monitor has not yet reviewed the State's compliance with this provision.

886

887 V.B.4-5 *Quality Assurance and Performance Improvement: If harm occurs despite these*
888 *measures, the responsible State, IMD or community provider will complete a root*
889 *cause analysis within 10 days. Using the results of the root cause analysis, the State,*
890 *IMD or community provider will develop and implement a corrective action to prevent*
891 *future harm.*

892 **Partial Compliance.** One Sentinel Event occurred at DPC during this period. DSAMH complied
893 with these and other relevant provisions of the Settlement Agreement, conducting a very
894 thorough root cause analysis. This analysis revealed some areas for improvement (now being
895 pursued—for example, relating to staff training—but no evidence of widespread systemic
896 departures from professional practice. Although the incident involved the death of an individual,
897 by all accounts the DPC staff's emergency response was exemplary.

898 One additional event, a patient-on-patient assault at DPC resulting in serious injuries that are not
899 life-threatening, occurred as this report was being finalized. DSAMH's root cause analysis and
900 other information pertinent to an assessment of this incident and how it was handled will not be
901 available until the next reporting period. The Monitor's next report will include such an
902 assessment.

903

904 **V. Summary**

905 The Monitor is pleased to report that Delaware has made significant advances toward
906 compliance with the Settlement Agreement during this initial six-month implementation period.
907 The State is working effectively to meet the requirements of its specific provisions, including
908 those that were scheduled for achievement during this reporting period and those that require
909 preparatory actions in order to meet upcoming target dates. Of equal importance, the State is
910 taking some very important steps to correct longstanding structural matters that now compromise
911 the civil rights of individuals with SPMI, and obstruct the effective provision and management of
912 the services afforded them through public programs. The Monitor commends the effectiveness of
913 DHSS Secretary Rita Landgraf and DSAMH Director Kevin Ann Huckshorn in creating a
914 climate for collaboration toward meaningful change, and applauds the stakeholders at all levels
915 whose dedication and innovation can make the important goals of the Settlement Agreement a
916 reality.

917

918 Respectfully Submitted,

919

920 Robert Bernstein, Ph.D.
921 Court Monitor