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

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

March 8, 2013

I. Introduction

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

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

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

II. Ratings of Compliance with the Agreement

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

III.G *Intensive Case Management*

I. By July 1, 2012 the State will develop and begin to utilize 3 ICM teams.

II. By January 1, 2013, the State will develop and begin to utilize 1 additional ICM team.

Substantial Compliance.

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

III. Progress on Other Provisions of the Agreement

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

A. Data Systems

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

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

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

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

B. Target Priority Population List

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

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

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

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

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

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

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

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

Recommendations:

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

C. Crisis Walk-In Centers

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

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

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

D. Civil Commitment

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, the Monitor now recommends:

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

E. Inpatient Psychiatric Care

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

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

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

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

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

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

<u>Recommendation:</u>

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

F. Mobile Crisis Teams

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

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

G. Transition Planning

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

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

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

H. Substance Abuse

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

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

I. Impact of Delaware's *Olmstead* Reforms

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

A critically important goal embedded in the Agreement is that "people with SPMI can live like the rest of Delawareans" (Section II.E.1.a). This goal reflects the essence of the ADA, yet is not easily captured in numeric data or even by the existence of a new program. For this reason, in addition to reviewing data, the Monitor spends a good deal of time interacting with stakeholders to get a sense of the on-the-ground meaning of the recent improvements in services. These interactions regularly include parties who are positioned to see what is actually occurring: individual consumers of public mental health services; representatives of the vibrant and insightful peer movement that has taken hold in the State; advocates including NAMI, the Mental Health Association; individual providers; and provider associations such as DelARF (the Delaware Association of Rehabilitation Facilities). If the opinions of these diverse stakeholders over the18 months of implementation can be encapsulated, it would be that skepticism based on a history of broken promises is giving way to a sense of optimism. Certainly, the transition process continues to present some real challenges, but there is an increasingly unified view that things are heading in a good direction, and a sense of pride at what has been accomplished thus far.

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

J. Integrated Supported Housing

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

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

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

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

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

K. Supported Employment

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

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

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

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

III. Summary

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

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

Respectfully Submitted,

Robert Bernstein, Ph.D.
Court Monitor

Attachment 1

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