

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

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

6
7 September 24, 2013

8 (Originally filed September 16, 2013)

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12 **I. Introduction**

13 This is the fourth report of the Court Monitor (“Monitor”) on the implementation of the
14 above-referenced Settlement Agreement (“Agreement”) between the United States,
15 through the U.S. Department of Justice (“DOJ”), and the State of Delaware (“the State”).
16 This report covers the six-month period January 15, 2013 through July 15, 2013 and it
17 reflects the State’s two full years of progress.

18 Whereas the last report covered a period in which the Agreement specified only one new
19 requirement (relating to Intensive Care Management), the current report coincides with
20 requirements relating to numerous new benchmarks that cover a range of program areas.
21 As is detailed below, Delaware has met—and often surpassed—each of the targets
22 scheduled to be achieved in this review period.

23 Furthermore, the State is making progress in addressing what might be called *structural*
24 issues, factors that cut across specific provisions, but that have been cited in prior reports
25 by the Monitor as being critical to achieving the immediate and long-term requirements
26 of the Agreement. These structural issues include the use of data, the reliance on court-
27 ordered treatment, and the State’s complex arrangements for the management of inpatient
28 and outpatient services.

29 Because each of these issues has implications for multiple measures of compliance with
30 the Agreement, this report begins with a discussion of progress in these structural areas,
31 followed by an evaluation of compliance with specific provisions of the Agreement. In
32 several instances, explanations of the State’s compliance with individual requirements of
33 the Agreement refer back to the broader measures the State is taking to address
34 underlying structural issues.

36 **II. Progress on Structural Improvements**

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38 **A. Use of Data**

39 In keeping with recommendations in the Monitor’s past reports, the State has been
40 working to improve its capacities for capturing good data and using this information to
41 monitor service quality and guide decision making. This is happening on two tracks.
42 While Delaware is proceeding with a program of broad, long-term upgrades to its
43 information technology (“IT”) systems, it is also moving forward on some more
44 immediate, and much-needed, expansions of capacities within DSAMH that are essential
45 to its meeting the requirements of the Agreement. These short-term measures are still
46 incomplete, but they are already offering a glimpse of how a fully functional information
47 system can vastly increase the State's abilities to monitor the quality, impact and
48 efficiency of DSAMH's services to individuals with SPMI. As an example, four new IT
49 positions are being requested by DSAMH. These will address a critical need for data
50 analytics that are specifically tailored to people with SPMI and the multiple systems that
51 serve them. Further progress is being made with the imminent adoption of electronic
52 medical records at Delaware Psychiatric Center (“DPC”); this should vastly improve
53 access to clinical information and related quality assurance.

54 As has been noted in previous reports, in many respects DSAMH has been accustomed to
55 functioning in the absence of timely and reliable data, and this has hampered its abilities
56 to maximize outcomes and efficiencies. During the past six months, the Monitor has
57 been working very closely with leadership in the Division to systematically incorporate
58 data in its tracking of compliance with the Settlement Agreement. DSAMH has created a
59 “dashboard” that reflects its current status with regard to each of the Settlement’s key
60 elements and that supplies data essential to compliance monitoring (both internally and
61 by the Monitor). In addition, it has begun to produce trending data relating to these
62 elements and other performance indicators.

63 The State’s significant progress in this area since the last report is evidenced throughout
64 this report, which incorporates several of the trending charts that are beginning to be used
65 on a routine basis to evaluate services and their impact. Again, while acknowledging
66 the State’s significant advances during the last six months, the data set reflected in this
67 report should properly be regarded as a work in progress.

68
69 *Targeted Priority Population List:*

70 One early challenge confronting the State with respect to data concerned the
71 establishment of a Targeted Priority Population List (“TPPL”), in keeping with Section
72 II.B of the Agreement. The construction and maintenance of this list have required the

73 State to integrate disparate data across departmental divisions, among them mental
74 health, corrections, Medicaid and housing. This has been an enormous, but worthwhile
75 undertaking. While the TPPL continues to be refined over time, it provides an
76 increasingly clear picture of the population with Serious and Persistent Mental Illness
77 (SPMI) that is served by Delaware’s public systems. This information—much of which
78 was simply nonexistent in a usable format when the Agreement was formulated—now
79 provides essential information about strategies for compliance and for future planning.

80 The TPPL currently includes 8,254 individuals, whose historical or current characteristics
81 are as follows (an individual may be represented in more than one category):

- 82 • Treatment at DPC 8.25%
- 83 • Treatment in an IMD 53.76%
- 84 • Criminal justice contact..... 31.11%
- 85 • Homeless 27.67%
- 86 • Emergency room use for mental health..... 25.64%

87 These data not only show the levels of clinical and social disability of the targeted
88 population, but also the impact that improved outcomes (such as those that are being
89 realized through implementation of the Agreement) can have on multiple State systems.

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91 *Evaluation of Individuals Discharged From DPC Following Long Hospitalizations:*

92 DSAMH is beginning to apply its improving data capacities to generate studies that focus
93 on specific service issues. A recently completed evaluation in collaboration with the
94 Monitor demonstrates the Division’s growing ability to evaluate the impact of new
95 programs created in accordance with the Agreement, as well as changes it is making in
96 practices to reduce its reliance on court-ordered treatment. A summary of this evaluation
97 and its important findings is presented below.

98 Description of the Population-

99 The evaluation focused on a high-risk, high-expense population of individuals who were
100 discharged from DPC between July 1, 2012 and June 30, 2013, following at least 60 days
101 of continuous inpatient care. The 105 individuals who met these criteria have extensive
102 inpatient histories, averaging 1147.1 days (about 3 years) at DPC, with a median length
103 of stay of 140 days (about 4.6 months).¹ Some of the individuals who were discharged
104 into more integrated community settings had been at DPC since the 1960s.

¹ The median is the number of days of continuous inpatient care received by half of this group. The divergence of the mean (i.e., the average) days of care and the median days of care reflects the inclusion of some individuals who had extremely long durations of hospitalization.

105 The community services to which these individuals were referred were as follows:

- 106 • 72 of these individuals (68.6%) were referred to the high-end community
107 services created pursuant to the Settlement: Assertive Community
108 Treatment (ACT), Intensive Care Management (ICM), or the Community
109 Reintegration Support Program (CRISP).
- 110 • 11 (10.5%) received Targeted Care Management (TCM) that was created
111 pursuant to the Settlement.
- 112 • The remaining individuals were referred to state-operated community
113 clinics or other programs.

114 The living arrangements to which the vast majority of these individuals were referred—
115 80.9%—affirm that, even for this high-need population, integrated community living is a
116 viable option. The specific breakdown of were living arrangements is follows:

- 117 • 23 individuals (21.9%) received SRAP vouchers to enable them to live in
118 scattered-site supported housing.
- 119 • 38 (36.2%) received needed housing supports (in scattered-sites, unless
120 otherwise approved following DSAMH’s review process) through the
121 CRISP program.
- 122 • 24 (22.8%) returned to their family homes with needed supports.
- 123 • 3 (2.9%) were referred to group homes.
- 124 • The remaining 17 individuals (16.2%), following DSAMH’s review
125 process, went to other settings consistent with their needs.

126 The information presented above demonstrates the State’s effectiveness in moving from
127 an institutional model of services to far more integrated settings.

128 This group’s level of need is not only reflected in its protracted stays at DPC—together,
129 members of the group consumed 120,447 hospital days during their last admissions—but
130 they also have very significant functional deficits. The Global Assessment of Functioning
131 scale (GAF) is a measure from 0 to 100 that is commonly used in mental health to assess
132 an individual’s status. At the point of their discharge from DPC, the average GAF for
133 this group was 28.1, which indicates:

134 Behavior is considerably influenced by delusions or hallucinations OR
135 serious impairment in communication or judgment (e.g., sometimes
136 incoherent, acts grossly inappropriately, suicidal preoccupation) OR
137 inability to function in almost all areas (e.g., stays in bed all day; no
138 job, home, or friends).²

² American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.) (p.34). Washington, DC: Author.

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Legal Status-

As is discussed in the next section, the State has been making significant efforts to move away from court-ordered treatment (both inpatient and outpatient) and towards a system that is much more oriented towards voluntary services. During the period covered by this study, DSAMH took some important measures to reduce referrals for outpatient commitment, and rates of these court orders have declined accordingly. Given the histories of most of the individuals included in this study (multiple hospitalizations, criminal justice involvement, emergency room use, very significant levels of disability and so on), this is the population that is often considered as appropriate for court supervision following discharge.

The study had some surprising (and positive) findings in terms of how individuals fared with or without court-ordered treatment. Of the 105 individuals, 26 (24.8%) were discharged with a continuing order for outpatient commitment; 79 (75.2%) were not under a court order. The mean GAF score for individuals who were discharged on outpatient commitment 26.8 and the median was 25. The mean GAF score for individuals who were discharged without a court order was 28.6, with a median of 30. For both groups, the similarity of the mean and the median suggests a normal (“bell-shaped”) distribution that is not skewed by outlier GAF scores.

Further analysis of these data yielded an important finding; contrary to what one might have expected, the group of individuals who were outpatient committed was not more impaired than the group with no court order. In other words, both groups comprise individuals with severe functional disabilities, and the GAF scores of those with court-ordered treatment in the community were not significantly different from those who were not subject to continuing court supervision.³ Accordingly, whether there were differences in how these individuals fared in the community can be helpful to the State as it continues to roll out processes aimed at increasing voluntary services and as it studies potential changes in its mental health laws.

Readmission Rates-

The chart below presents the 30- and 180-day readmission rates of these 105 individuals who were discharged in the past year, following 60 days or more of continuous inpatient care at DPC. For comparison are the most recently published national readmission rates and those for the state of Delaware.

³ In a one-tail t-Test, t=-0.926, P=0.178, ns.

	30-DAY READMISSION RATE	180-DAY READMISSION RATE
Post-Discharge DPC Population of 105 Individuals:		
Readmission Rates ⁴	4.7%	13.2%
Comparison Rates:		
U.S. Rates (SAMHSA, 2011)	9.3%	21.0%
Delaware Rates (2013)	9.6%	23.1%

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176 Fourteen (14) members of this group (13.2%) were re-hospitalized within 180 days of
 177 their discharge from DPC, 5 of whom (4.7%) were readmitted within thirty days.
 178 Notwithstanding the histories and functional levels of these individuals that place these
 179 individuals at very high risk of failure in the community, these readmission rates are at
 180 least 45% lower than the national rates for 180-day and 30-day readmissions (21.0% and
 181 9.3%, respectively⁵) and the Delaware’s overall psychiatric readmission rates (which are
 182 very consistent with these national norms). Most importantly, These significant findings
 183 highlight that, even for this at-risk group, the intensive services and integrated housing
 184 opportunities that the State has created pursuant to the Settlement Agreement are being
 185 successful in maintaining people with serious and persistent mental illnesses within the
 186 community. In fact, these individuals actually have lower rates of psychiatric
 187 rehospitalization than does the general population of individuals with serious mental
 188 illness.

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190 Fiscal Impact-

191 It is worth noting that, based on an estimated cost of care within DPC of \$800 per day,
 192 the median length of stay of 140 days would mean hospital costs of about \$112,000 per
 193 person. Applying the average length of stay of this group of 1,147.1 days, a rough
 194 estimate of the cost incurred for their hospital care is a remarkable \$917,680 per person.
 195 A meaningful cost estimate would be somewhere between these figures but, no doubt,
 196 would be substantial.

197 In any event, given that care within DPC is generally not reimbursable through Medicaid
 198 or other insurance, these costs have largely been borne by the state of Delaware. In

⁴ Readmission rates are calculated as a percentage of the 105 individuals who were discharged from DPC in fiscal year 2013 following 60+ days of hospital care and who were re-hospitalized for psychiatric care.

⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Outcomes Measures, 2011.

199 contrast, many of the services being provided to these individuals within the community
 200 are not only lower cost, but they draw in federal dollars through Medicaid or other
 201 programs. The average annual total cost of supporting an individual in the community
 202 with Assertive Community Treatment (ACT) services is \$23,500 (\$15,000 for ACT
 203 services + \$8,500 for SRAP housing supports). Taking into account that ACT services
 204 are reimbursable through Medicaid and draw federal dollars, the costs to the State are
 205 even lower, approximately \$16,000 (\$7,500 state Medicaid match for ACT + \$8,500 for
 206 SRAP housing supports). In other words, applying the more conservative median cost of
 207 hospitalization at DPC of \$112,000 per person, the community supports to these
 208 individuals pursuant to the Agreement represent savings to the state of about 86%. The
 209 table below summarizes annualized projections (since the mean length of stay for this
 210 group was greater than one year, full year costs are presented instead):

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**Cost Comparison of Evaluation Group:
 DPC vs. Intensive Community Services**

	Annual Cost Basis	Total Annual Cost		Federal Medicaid	Net State Cost	
DPC	Hospital Days:	Median 140	Full Year 365		Median 140	Full Year 365
	Inpatient care @\$800	\$112,000	\$292,000	\$0	\$112,000	\$292,000
Community	ACT @\$15,000 + SRAP Housing @\$8,500	\$23,500		\$7,500	\$16,000	
Range of Annual Savings/Person:		\$88,500 to \$268,500			\$96,000 to \$276,000	

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214 Readmissions and Legal Status-

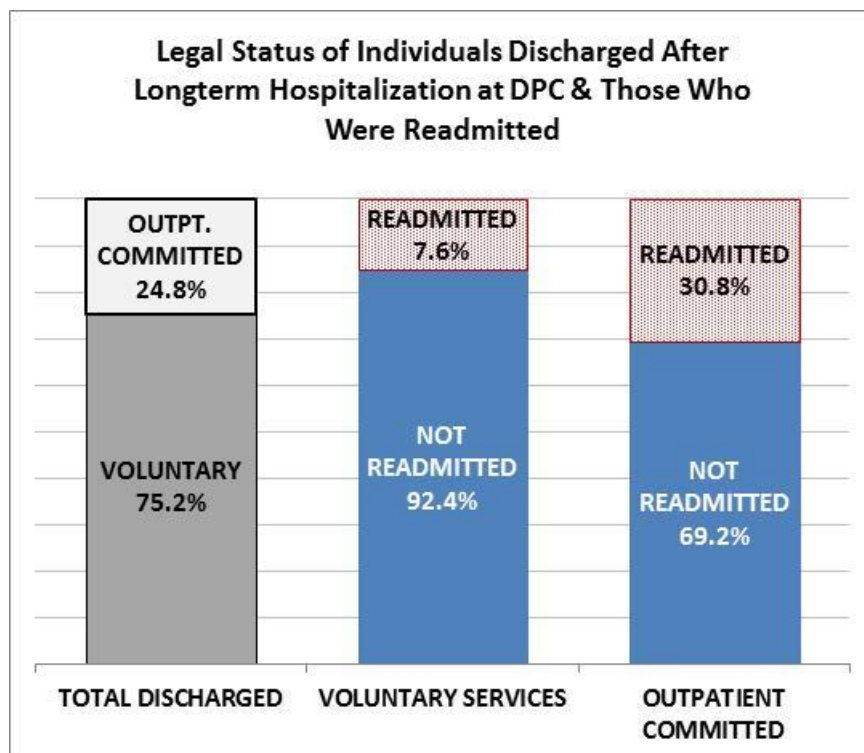
215 Finally, this evaluation yielded some very interesting information regarding outpatient
 216 commitment and its impact. Generally, proponents of outpatient commitment assert that
 217 for people with serious mental illness and significant impairments—both of which
 218 characterize this group—court intervention improves outcomes and results in fewer
 219 hospitalizations. In contrast to outpatient commitment programs in some other states, in
 220 Delaware outpatient commitment does not entitle individuals to an enhanced package of
 221 services, nor does it improve one’s access to services.⁶

222 All of the individuals in this group had access to services in accordance with their
 223 discharge plans and needs, and their post-discharge legal status presented neither an

⁶ For example, in some states outpatient commitment is regarded as a means of jumping the queue and reducing time on a waiting list of services.

224 advantage nor a disadvantage in receiving these services. For example, as referenced
 225 above, 24.8% of the group was discharged on outpatient commitment status, but 68.6%
 226 received high-end services such as ACT. The individuals who were outpatient
 227 committed received the same level of service and access to housing as those who were
 228 not. That being said, and considering that the functional status of these two groups was
 229 essentially the same, it was interesting to find that individuals who were outpatient
 230 committed were much *more*—not *less*—likely to be re-hospitalized than those who were
 231 receiving community services voluntarily.

232 The chart below summarizes the striking differences between these groups. Of the 79
 233 individuals who were discharged without an outpatient commitment order, only 6 (7.6%)
 234 were readmitted. Individuals who had outpatient commitment orders were about four
 235 times more likely to be readmitted than were those who were receiving the same services
 236 voluntarily.



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 238 Recommendations:

239 This evaluation demonstrates movement within DSAMH towards much more
 240 data-driven oversight of services and their impact, as well as the potential for
 241 information technology to inform planning and policy decisions. As evidenced by
 242 this evaluation and data presented throughout this report, the State has made
 243 palpable progress in this area. Nevertheless, the data presented here are best
 244 regarded as a preview. DSAMH remains significantly limited in its abilities to

245 produce and appropriately analyze data in ways that will maximize its
246 performance. It is important that it quickly move forward on its plans to expand
247 its IT capacities with individuals who are versed in data analysis, as well as the
248 array of services and systems affecting the population covered by this Agreement.

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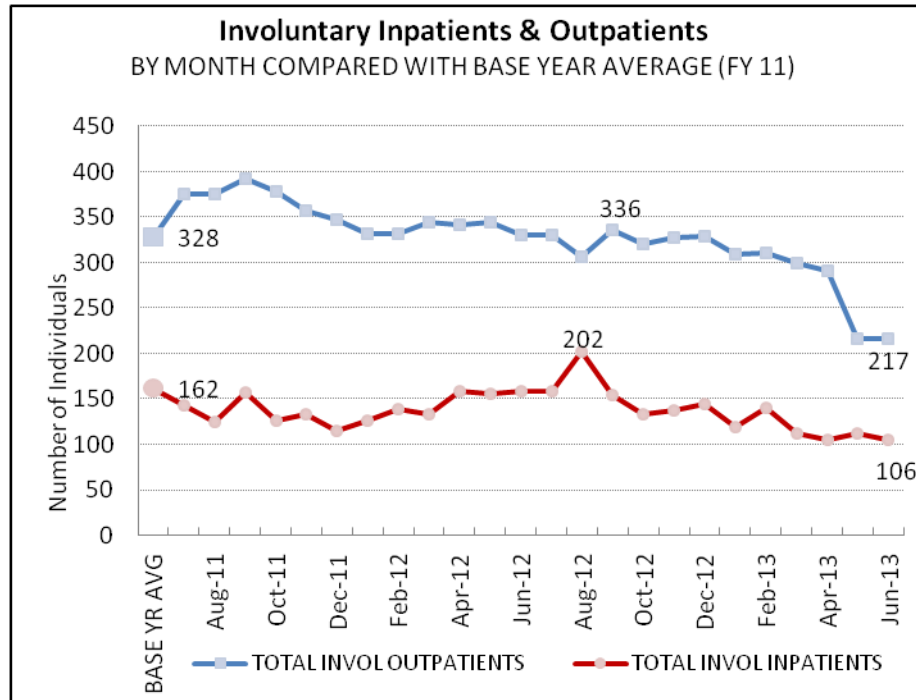
250 **B. Reliance on Court-Ordered Treatment**

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

257 Judicial involvement in mental healthcare should be a last-resort, emergency measure.
258 When it becomes necessary to turn to the courts, an assessment should be triggered to
259 determine how earlier-on voluntary services might have averted the involvement coercive
260 treatment. Unwarranted involuntary treatment—including court-ordered treatment to
261 reduce providers’ perceived liability, assure payment, or as a substitute for good
262 consumer engagement—is not the “least-restrictive” approach consistent individuals’
263 rights under the ADA and other state and federal laws. Furthermore, absent a specific
264 and carefully considered individual need, coerced treatment is inconsistent with the
265 recovery orientation that DSAMH is pursuing system wide.

266 The State continues to take significant steps to move to a much more voluntary system of
267 services. On a case-by-case basis, DSAMH will now reimburse IMDs for the cost of
268 needed inpatient care in the absence of a court order. Further, both the Division and
269 representatives of the State Attorney General’s office have been working with providers
270 and the courts to ensure that orders relating to outpatient commitment are based on
271 specific, well justified, and demonstrably least-restrictive requests, with clarity as to what
272 is required of the individual to demonstrate compliance.

273 The chart below presents the State’s continuing, dramatic progress in reducing its
274 reliance on court-ordered treatment for both inpatient and outpatient services. The chart
275 shows the number of individuals who were under active civil commitment orders each
276 month by type of order, as well as the monthly average for the year prior to
277 implementation of the Agreement (i.e., June 15, 2010-July 15, 2011). Overall it shows
278 about a 34% decrease in both inpatient and outpatient commitments relative to that base
279 year.



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These trend data not only allow the State to evaluate its progress, but also are informative about the impact of its interventions. For example, revisions in the Delaware’s law with respect to outpatient commitment are currently under discussion by a legislatively mandated study group and the State is about to issue new guidance with more specific requirements for how providers may petition for outpatient commitment. Neither of these efforts was completed at the time the above chart was generated. Yet, the graph shows a dramatic decrease between February and May of 2013—about 27% —in the number of people with outpatient commitments. These occurred as DSAMH began apprising stakeholders of the impending changes in the process for seeking outpatient commitments.

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It is reasonable to expect that Delaware will continue its trajectory of reducing its reliance on court ordered services, particularly as the planned procedural changes in the outpatient commitment process go into effect, the impact of crisis and diversion services (discussed below) continues to expand, and further refinements are made in the legal and policy framework in which services are delivered. As is evidenced in the data presented in this and the prior sections, DSAMH is rapidly expanding its capacities to capture and analyze data relating to the reliance on court-ordered treatment and how individuals are faring in a system more oriented towards voluntary services.

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300 C. Management of Clinical Services

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Past Monitor reports have called attention to the State’s overly complex systems for managing the care of individuals receiving public mental health services. Essentially,

303 depending upon an individual’s status with regard to Medicaid, during the course of a
304 year an individual’s care may be overseen by DSAMH; or the Division of Medicaid and
305 Medical Assistance (“DMMA”), via a managed care organization (“MCO”); or a
306 combination of the two. This arrangement has built-in inefficiencies and inconsistencies
307 in addressing the needs of people with serious and persistent mental illness.

308 Matters are further complicated as the Affordable Care Act comes into effect, as many
309 individuals with SPMI who have heretofore been supported with State dollars through
310 DSAMH will be newly eligible for Medicaid or have access to insurance via the
311 marketplace. Furthermore, the State is pursuing changes in its Medicaid plan which will
312 expand coverage for services such as supported employment and care management. In
313 all instances, it is important that individuals be afforded appropriate access to services
314 and monitoring to ensure that these services are necessary and having their intended
315 benefits.

316 Each of the Monitor’s prior reports has discussed how the current care management
317 arrangement, with its shifting responsibilities, is problematic. This is particularly the
318 case with respect to the State’s obligations under the Agreement to reduce its psychiatric
319 inpatient bed-days (See discussion of Crisis Stabilization Services below).

320 Notwithstanding the Monitor’s prior recommendations, the State’s disjointed
321 arrangements for managing inpatient and other services to individuals with SPMI persist
322 to this day, and the State still does not have a specific plan to improve this critical
323 oversight function.

324 The discussion of Crisis Stabilization Services includes a chart entitled “Inpatient Days
325 by Provider Type by Month.” This chart shows that, over time, DPC is accounting for a
326 significantly decreasing proportion of inpatient bed-days, that bed-day use in the IMDs
327 has been fairly constant when managed by DSAMH, and that it is trending upward when
328 managed by DMMA via the MCOs. Fulfilling the requirements of the Agreement will
329 require not only a continuation of bed-reduction efforts at DPC, but a much more
330 concerted approach to manage inpatient utilization within the IMDs.

331 • *Inpatient Care Management by DSAMH*

332 Individuals’ inpatient care in IMDs is managed by DSAMH’s Eligibility and
333 Enrollment Unit (“EEU”) when they are uninsured, when they have been carved
334 out for high-end services (such as Assertive Community Treatment), or when
335 individuals who have Medicaid coverage have exhausted their benefits under the
336 capitated managed care contracts DMMA holds with MCOs.

337 The EEU is not staffed to review and approve admissions before they occur.
338 However, when an individual is admitted with DSAMH as the payor, that
339 individual has gone through one or more gatekeepers within the mental health
340 system (e.g., a Crisis Walk-In Center, Mobile Crisis), and a determination has

341 been made that alternatives to inpatient care (such as Crisis Apartments) are not
342 viable. DSAMH has recently expanded its capacity to conduct on-site Utilization
343 Review at the IMDs. Typically, approval for inpatient care is given in 24-hour
344 increments.

345 • *Inpatient Care Management by DMMA*

346 Inpatient care is managed by DMMA when an individual is Medicaid eligible and
347 has not expended a 30-day annual inpatient benefit that is a part of the State’s
348 capitated managed care contracts with two privately-operated MCOs.

349 The general premise behind such capitated MCO arrangements with states is that
350 these organizations are allotted fixed (“capitated”) healthcare budgets based on
351 the number of individuals insured and their needs, and that the financial
352 incentives to contain costs and to reduce the risk of being financial liable for
353 overspending the capitated rate will improve efficiencies. The problem with the
354 psychiatric inpatient arrangement with the MCOs in Delaware is that these
355 organizations are not at full risk. Instead of the MCO being liable for the full cost
356 of an insured individual’s inpatient psychiatric care, once the Medicaid benefit is
357 used up, DSAMH picks up any further inpatient psychiatric costs. In other words,
358 the degree of the MCO’s risk—ostensibly a significant driver of cost-efficient
359 care in the managed care world—is limited by the 30-day annual benefit.

360 As is the case with DSAMH, most inpatient care is approved after an individual
361 has already been admitted to an IMD and reviews take place during regular
362 weekday business hours. IMDs have up to 48 hours following admission to
363 submit documentation to MCOs for a determination of whether hospital care is
364 needed (although the admission has already occurred). Per DMMA, denials of
365 admission by MCOs are estimated to occur less than 10% of the time. On average,
366 the approval is granted for 6.4 days.

367 People with SPMI whose hospital admissions are managed by the MCOs may—
368 or may not—have passed through DSAMH’s gatekeeping and diversion
369 processes. This is particularly problematic because, MCOs’ decision making has
370 not been well integrated with the full array of alternatives available through
371 DSAMH (many of these alternatives, such as Crisis Apartments and Targeted
372 Care Management, were developed pursuant to this Agreement).

373 Finally, it is important to note that although DMMA contracts with these private
374 entities (similarly, DSAMH contracts with private providers for mental health
375 services), the responsibility for fulfillment of this Agreement and the
376 requirements of the ADA rests with the State. DMMA will need to make this a
377 priority and to work much more closely with the MCOs to assure that Medicaid-

378 funded services to individuals with serious mental illness are in accordance with
379 the ADA and the Agreement.

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381 During the past year, the Monitor has been working closely with leadership in DHSS,
382 DSAMH and DMMA to craft a plan for services management that will further the State's
383 compliance with this Agreement, streamline its oversight of services and outcomes for
384 people with serious mental illness, and ensure that public dollars are being utilized in
385 ways that reduce costly hospitalizations. This work is ongoing and reflects collaboration
386 across Divisions. However, two years into implementation of the Agreement, there is
387 still no basic framework for how this critical oversight will occur.

388 With respect to the State's obligations under the Agreement, a more coherent and unified
389 process for services management has critical and very time-sensitive implications. For
390 example, as is discussed later in this report, the Agreement includes an important
391 requirement that inpatient bed-days be reduced by 30% in about a year. Achievement of
392 this goal will reflect the culmination of most of the program reforms required by the
393 Agreement (for instance, Mobile Crisis, ACT, and Crisis Apartments), but it cannot rely
394 on those alone. It will also require careful control over hospitalizations. Care
395 management must integrate each of these elements, and it must consider (and produce)
396 timely and consistent data. Finally, as the Monitor has repeatedly recommended in the
397 past, there should be a single, centralized point of accountability for management of
398 hospital admissions, regardless of the public payor. The discussion below relating to
399 hospital bed-day reduction further reinforces the importance of quickly moving ahead in
400 resolving this issue.

401 Recommendations:

402 1. The Monitor is actively working with DSAMH and DMMA to bring about
403 some immediate measures to reduce acute care bed-days in the IMDs and
404 DPC. These include expansions in on-site Utilization Review by DSAMH
405 and plans for intensive meetings (beginning on a weekly basis) between the
406 DHSS Secretary's office, leadership at DMMA and the MCOs. The two
407 divisions are now working on a work plan with timelines for implementing
408 various immediate-term activities aimed at the achievement of the bed-day
409 reductions required in the Agreement. A long-range plan is still lacking and
410 needs to be developed concurrently.

411 Apropos of the above discussion of data systems, these actions are tied to
412 regular statistical reports on how the State is faring in terms of meeting its
413 bed-use requirements and how various interventions by this collaboration are
414 furthering efforts to meet the benchmarks included in the Agreement. Not
415 only in fulfillment of the Agreement, but because of pending changes in the

416 State's Medicaid plan and the new Medicaid expansions under the Affordable
417 Care Act, it is very strongly recommended that the parties aggressively move
418 to craft an immediate and longer-range management strategy.

419 2. Regardless of payor, the State's arrangements for managing services to
420 individuals with serious mental illness need to improve, unifying oversight of
421 inpatient utilization and ensuring that individuals at risk of hospital admission
422 are appropriately evaluated for less restrictive, less expensive alternatives.
423 What is urgently needed is a single point of accountability.

424 3. The clinical criteria applied to determine the need for inpatient psychiatric
425 care and whether less intrusive alternatives are appropriate should be the
426 same, whether DMMA or DSAMH is paying for the cost of hospitalization.

427 4. Because it is much harder to implement alternatives to unnecessary hospital
428 care—and much more disruptive for the individual—when these
429 determinations are made after an admission has taken place, DHSS, DSAMH
430 and DMMA should assure that certification of the need for admission occurs
431 prior to an individual's transfer to an IMD. Pre-certification reviews should
432 not be limited to regular business hours, but should be available on a 7-
433 day/24-hour basis, as needed.

434 5. Continuing stay reviews for individuals deemed in need of hospital care
435 should take place on weekends, as well as during the work week. This is
436 particularly critical for individuals with SPMI who may be hospitalized on an
437 involuntary basis.

438 6. The Monitor supports DMMA's plan to significantly intensify its oversight of
439 the MCOs with respect to the achievement of all relevant requirements of the
440 Agreement.

441 7. DMMA and DSAMH should immediately establish mechanisms for sharing
442 and consolidating timely information about inpatient utilization, unmet needs
443 in the community, and other key benchmarks of compliance with this
444 Agreement. Status reports should be provided to the Monitor at least on a
445 monthly basis.

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448 **III. Ratings of Compliance with the Agreement**

449 The three structural issues discussed in the previous section have very important
450 implications for all of the programs required through the specific provisions of the
451 Agreement, which are discussed below. Appropriate monitoring of the utilization and
452 impact of these programs requires a workable system of care management that is guided
453 by complete and meaningful data. Furthermore, the ubiquitous goal of providing services
454 that are recovery-oriented requires that they be provided on a voluntary basis, and that
455 coercive court-ordered services occur only as a last resort.

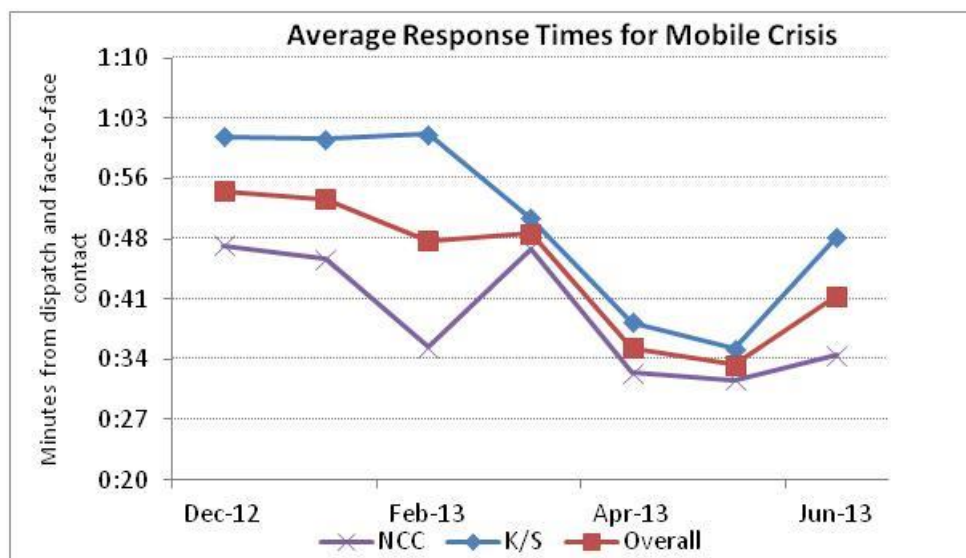
456 At this juncture, the State is in Substantial Compliance with each of the benchmarks of
457 the Agreement that are now required. In order to sustain its current success, it is essential
458 for the State to continue progress with respect to these structural matters.

459
460 **A. Mobile Crisis Services**

461 Substantial Compliance.

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

466 Furthermore, as required in Section III.B.1, the State is continuing to meet the
467 requirement of a one-hour response time to mobile crisis calls. The chart above
468 demonstrates DSAMH’s monthly monitoring of this provision for the teams stationed in



469 New Castle County and Kent/Sussex Counties.

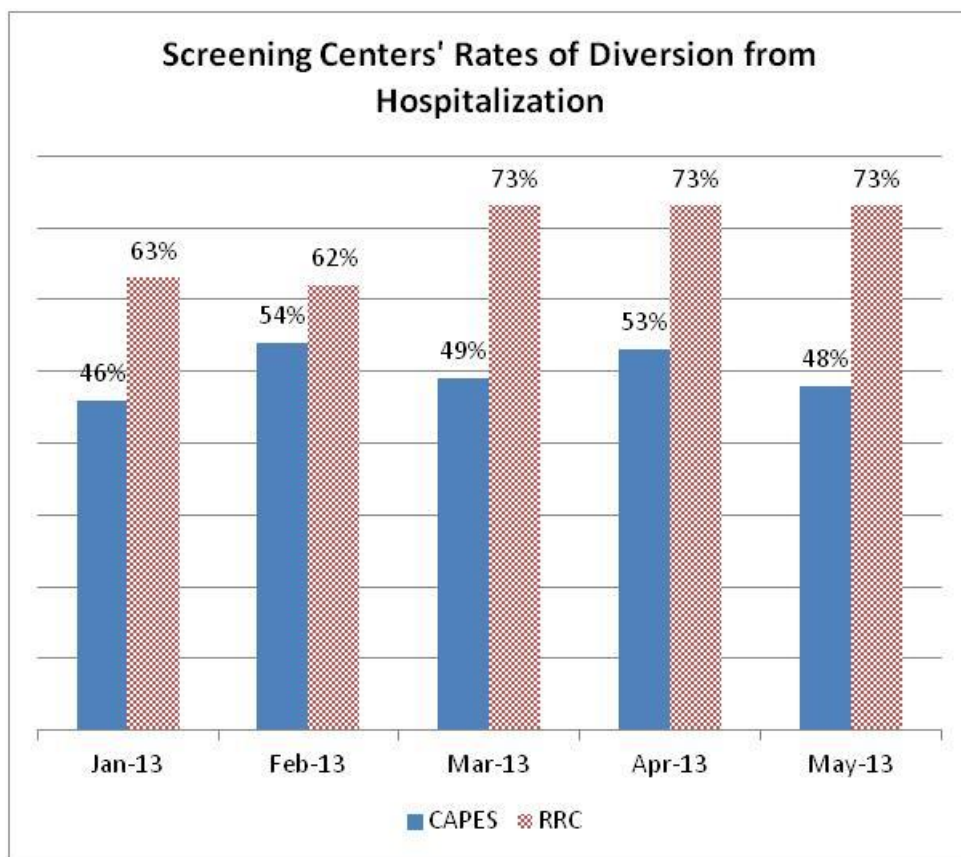
470

471 **B. Crisis Walk-in Centers**

472 Substantial Compliance.

473 Section III.C.2 of the Agreement requires the State to train all state and local law
474 enforcement personnel about the availability and purpose of the crisis walk-in centers and
475 the protocol for referring and transferring individuals to walk-in centers. The State is
476 providing ongoing training to state and local law enforcement in this regard.

477 In compliance with Section III.C.1, the State launched the Recovery Response Center
478 (RRC) in Ellendale about a year ago and it has been collecting data regarding its impact
479 and utilization. As is presented in the chart below, in May, 2013, RRC diverted from
480 hospitalization 73% of people evaluated. By way of comparison, the hospital-based
481 CAPES program, which serves the northern part of the state and utilizes a more
482 traditional model, diverted from hospitalization 48%% of the people assessed that month.
483 The following chart presents a comparison of the diversion rates for these two screening
484 centers during January through May of 2013. RRC estimates that substantial additional
485 individuals can be diverted from hospital care if it had a capacity for voluntary overnight



486 crisis stabilization.

487 When the walk-in center in Ellendale was being planned, there was a clear understanding
488 of the need for such a program in the southern part of the state, but a much less precise
489 understanding of what the demand for its services would be. RRC is already in the
490 position where it routinely has to delay or deny transfers in from hospital emergency
491 departments because it is at capacity. This information is being tracked by month, day,
492 and time of day so needed adjustments in the program's capacity can be designed
493 accordingly. Furthermore, RRC is collecting data on individuals who are being referred
494 elsewhere because their immediate need is for detox services. DSAMH is using this
495 information as it moves forward with some major improvements in its substance use
496 service network.

497

498 Recommendations:

- 499 1. The State should carefully examine whether the capacities of RRC reflect the
500 needs of the southern part of the Delaware in order to assure that there is ready
501 access to its services and that individuals appropriate for transfer to RRC do not
502 become backed up in emergency departments. Based on available data, it appears
503 that a good case can be made for expanding the program's capacities.
- 504 2. Not only for purposes of complying with the Agreement (e.g., with regard to the
505 hospital bed-day reductions discussed elsewhere), but also to improve cost
506 efficiencies, the State should evaluate an expansion of the Ellendale program to
507 include voluntary overnight crisis services.
- 508 3. Given the demonstrated success of RRC in diverting high percentages of
509 individuals assessed from hospital care, the State should develop a crisis walk-in
510 center applying its model for New Castle County.

511

512 **C. Crisis Stabilization Services**

513 Substantial Compliance.

514 Section III.D.2 of the Agreement requires that the State train all provider staff and law
515 enforcement personnel regarding the use of crisis walk-in centers rather than IMDs or
516 hospital emergency departments for individuals who are experiencing mental health
517 crises. The State is in Substantial Compliance with this requirement; it is providing
518 ongoing training to law enforcement, providers and other stakeholders statewide with
519 regard to the use of crisis walk-in centers.

520

521 Not only is the RRC relatively new and its program model non-traditional, but as
522 discussed above this walk-in center was launched in a part of the state that had lacked
523 alternatives to hospital emergency departments and that had become accustomed to
524 relying heavily on them. There is good reason to conclude that the RRC is having its
525 intended impact. Beebe Medical Center, one of the major hospitals serving the southern
526 part of the state, has reported a notable decrease in the number of psychiatric patients
527 being seen in its emergency department.

528

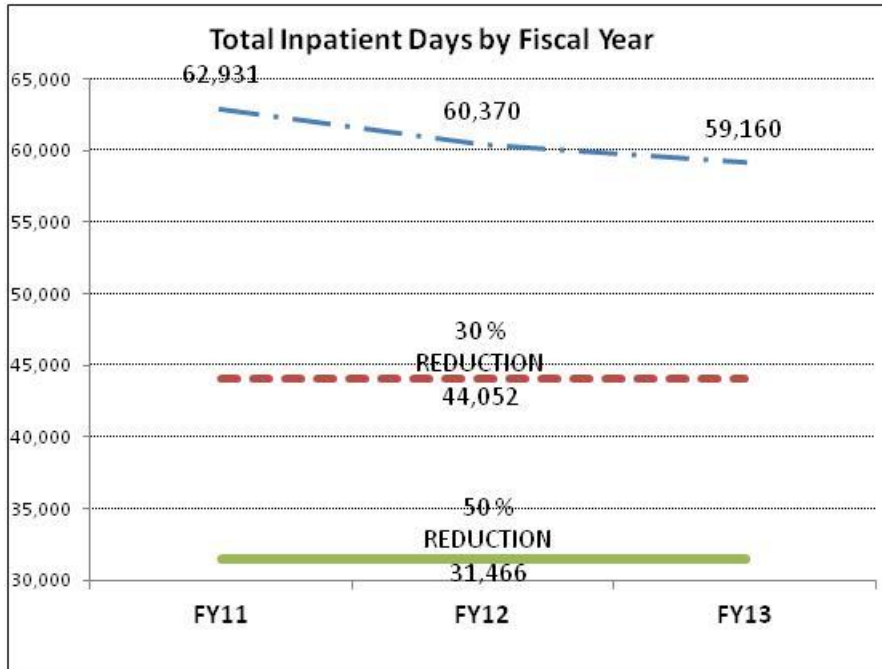
529 *Reduction in Inpatient Bed Days:*

530 Section III.D.3 of the Agreement requires that by about one year from now—July 1,
531 2014—the State will need to reduce its publicly funded inpatient bed days by 30% of its
532 baseline. While compliance with this provision is not yet required, this is a very
533 important requirement because it reflects the State’s success in moving from an
534 institutional model of services to one that promotes individuals with serious mental
535 illness living successfully in integrated community settings. Achievement of this
536 benchmark will represent the combined effects of a number of program and policy
537 elements required by the Agreement, among them, screening and diversion activities by
538 Mobile Crisis services, Crisis Walk-in Centers and House Bill 311; the impact of ACT,
539 CRISP and ICM; availability of Crisis Apartments; and careful management of clinical
540 services.

541 Furthermore, it reflects the State’s capacity to move from high-cost hospital care—the
542 evaluation presented above in the section relating to the Use of Data references (albeit in
543 very rough terms) the levels of savings that are potentially available—to more ADA
544 compliance and less costly community services. Accordingly, the State and the Monitor
545 have been carefully tracking trends in the use of bed days by the targeted population.
546 Again, DSAMH’s evolving capacities for data analytics is proving invaluable in
547 identifying progress and challenges in meeting this requirement.

548 For purposes of evaluation, the parties have agreed that the baseline to be used for
549 measuring compliance with this provision will be the number of publicly funded bed days
550 in DPC and the IMDs during the fiscal year preceding the effective date of the
551 Agreement (June 30, 2010 to July 1, 2011). During that period, people with serious
552 mental illness accounted for 62,931 bed-days. A 30% reduction from this baseline, to be
553 achieved by next July, is 44,052 bed days. The 50% reduction to be achieved by July,
554 2016 is 31,465. As is presented in the chart below, the State has made some progress
555 during the two years of implementing the Agreement (FY12 and FY13 in the chart), but
556 this has resulted in only a 6% decrease thus far.

557

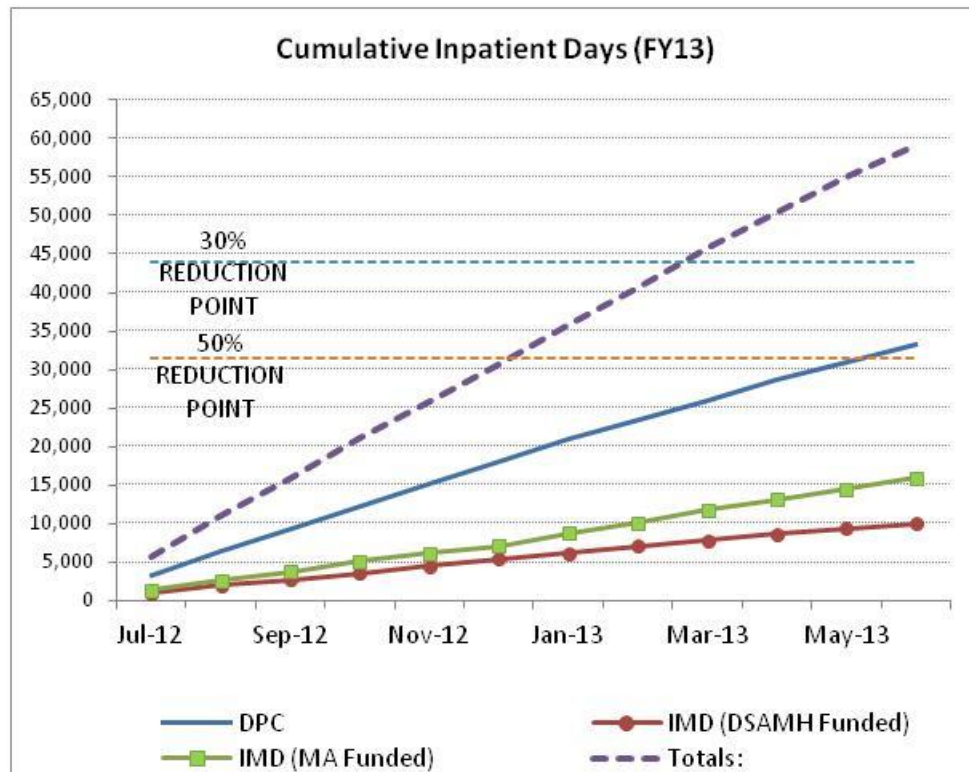


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The following charts further demonstrate how DSAMH is using data analytics to evaluate its status with respect to this important benchmark and to target its interventions



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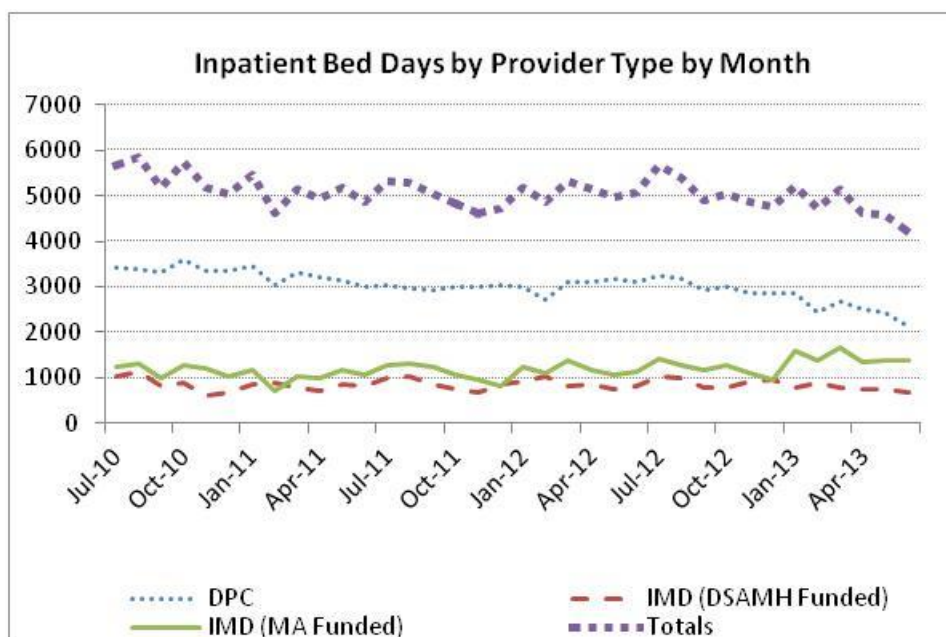
564

accordingly. The first chart shows a running total of accumulated bed-days during the past year and the relative contributions to the accumulated bed-days from DPC, from inpatient care in the IMDs that is controlled by Medicaid managed care (“MA Funded”),

565 and from inpatient care in IMDs that is managed by DSAMH (“DSAMH Funded”). This
 566 analysis shows that around March of the year, the State had already reached its annual
 567 target (i.e., the line for Total days intersects the 30% reduction line around March). In
 568 the subsequent months, the State was exceeding targeted limit. The greatest contributor
 569 to bed-days was DPC—in part, because it includes some individuals with much longer
 570 term hospital stays—followed by Medicaid managed acute care clients and then DSAMH
 571 managed acute care clients.

572 The second chart clarifies where DSAMH has been successful in achieving reductions in
 573 bed-days and where there are challenges that need special focus. It tracks the total bed
 574 days utilized each month (as opposed to the month-to-month running total in the first
 575 chart) by provider type over the past three years. The dotted line with the Totals shows
 576 the monthly use of bed-days and the slight drop that has occurred over time. The DPC

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580 line shows that, primarily through community discharges from long-term care, there has
 581 actually been a significant decrease in monthly bed-days, from 3,426 in July of 2010 to
 582 around 2,131 in June of 2013; that is a 38% reduction. In fact, DPC was able to close a
 583 long term care unit, bringing its civil beds down from 120 to 80. The bed-days associated
 584 with DSAMH-funded care in the IMDs have remained relatively unchanged over time,
 585 with a slight reduction. But the monthly bed-days under Medicaid managed care have
 586 actually increased, from 1,228 in July of 2010 to 1,373 in June of 2013—a growth of
 587 12%.

588 Based on these and other analyses, as well as the urging of DOJ, DSAMH has undertaken
589 several measures to meet the challenging targets for bed-use reduction. These include the
590 initiation of on-site utilization review by DSAMH for the individuals it funds within the
591 IMDs. DSAMH is receiving ongoing consultation by an expert contracted through the
592 Monitor to maximize the effectiveness of this new initiative. As is referenced in an
593 earlier section of this report, navigating the complicated interface with Medicaid
594 managed care is complicated for a number of technical reasons. The Director of DMMA
595 is fully—and positively—engaged in crafting a plan to help move the State to compliance
596 with this provision, and to do so in ways that maximize efficiencies and outcomes that are
597 consistent with the ADA.

598 Finally, it is worth reiterating that, though it may be difficult for the State to meet this
599 impending benchmark, its improving capacities to access and analyze data put it in a
600 wholly different position from prior years. The multiple charts are included in this report
601 to demonstrate how DSAMH is now able to evaluate performance and to target remedies
602 accordingly. The evaluation of individuals discharged from DPC (presented above)
603 demonstrates that a population that had accounted for very high numbers of hospital bed-
604 days can be successfully discharged with ACT, supported housing and other evidence-
605 based community services. Further referrals from DPC and the IMDs with the levels of
606 intensive support available through ACT, ICM and CRISP may result in additional
607 reductions and present a similarly positive return on an investment in integrating
608 community services.

609 Recommendations:

610 The recommendations (discussed elsewhere in this report) relating to the expansion in
611 the number of ACT teams, the development of an RRC-style Crisis Walk-in Center to
612 serve the northern part of the state, and reforms in how clinical services are managed
613 are essential for fulfilling this important requirement.

614

615 **D. Crisis Apartments**

616 Substantial Compliance.

617 Section III.E.2 of the Agreement requires the state to make 2 additional crisis apartments
618 available by July 1, 2013, bringing the total number of crisis apartments to 4. These
619 apartments are required to be situated so that individuals throughout the state in need of
620 this service can have access. The State has surpassed this requirement. There are now 9
621 crisis apartments situated throughout the state. DSAMH is monitoring their occupancy
622 patterns and is taking measures to ensure that Mobile Crisis Teams and other providers
623 are aware of the availability of beds. The typical length of stay in these crisis beds is
624 about three to seven days.

625

626 **E. Assertive Community Treatment**

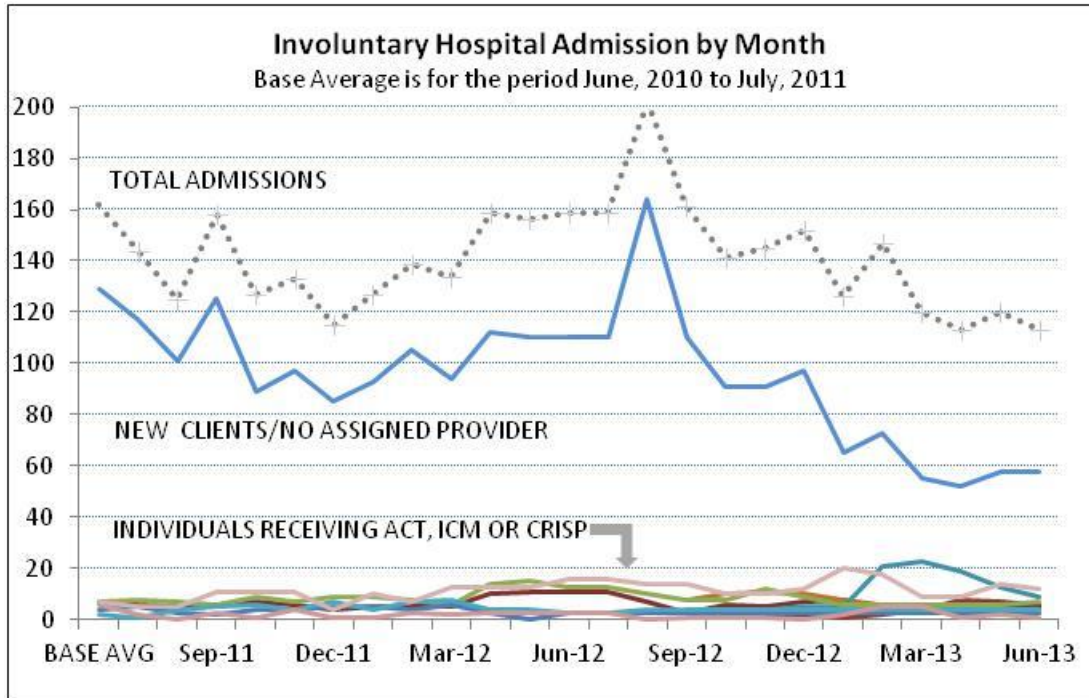
627 Substantial Compliance.

628 Section III.F.2 requires that the State establish 1 additional ACT team—bringing the total
629 to 9 ACT teams—by September 1, 2013. The State has already surpassed that target.
630 There are presently 11 ACT teams statewide. Nevertheless, there are now waiting lists of
631 individuals in need of ACT services in New Castle County because the teams there are
632 largely at capacity.

633 DSAMH is routinely assessing the fidelity of all 11 teams with the TMAC model, which
634 the parties have agreed to as a more recovery-oriented standard than the Dartmouth
635 model referenced in the Agreement. The teams are in various stages of development and
636 are receiving consultation and support, as needed, from DSAMH. During the past year,
637 one of the ACT providers discontinued services in the state, but DSAMH engaged
638 alternate providers without significant or sustained interruptions in services.

639 The Monitor recently had an opportunity to meet with a Sussex County ACT Team,
640 which was specifically selected because the southern part of the state has historically
641 been underserved. Individually and collectively the members of the team were
642 impressive in their knowledge of the status and needs of the individuals being served,
643 their focus on how individuals were navigating the various day-to-day demands of
644 community living, and their consideration of medication-related issues without allowing
645 these to become the dominant interest. One telltale quality of a well-functioning ACT
646 team was very much in evidence: The Monitor entered the team’s meeting while it was
647 already underway and, to avoid being disruptive, introductions of various members were
648 made after the fact. During the discussions taking place prior to these introductions, it
649 was very difficult to discern who was the doctor, the nurse, the case manager, the peer
650 specialist, and so on. All were very active participants and there was clearly an interest in
651 what every member had to contribute. Each member appeared to have a working
652 knowledge of not only the individual’s clinical needs, but what was going on in that
653 individual’s life. This small observation is an important measure of a good ACT team,
654 where professional roles (and associated hierarchies) are intended to be blurred and
655 where there is a collaborative effort to assist the individual in meeting his or her needs..

656 On a more global level, DSAMH has data that demonstrate the effectiveness of the ACT
657 model and other community programs. The chart below shows that individuals being
658 served by ACT, Intensive Care Management (discussed in the next section) and CRISP
659 account for very few involuntary hospitalizations. This occurs even though these
660 programs serve individuals who have significant disabilities, generally with long histories
661 of recurrent hospital admissions. In contrast, the great majority of hospital admissions
662 involve individuals who are new to the system or those being served by private
663 practitioners, many of whom are being served through MCO care management—a
664 population that tends to be higher functioning.



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These data, as well as the individuals’ stories presented below in regard to supported housing and employment, affirm that the State’s ACT programs are serving an essential role in achieving the requirements of the Agreement.

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Recommendations:

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Based on the waiting list for ACT in New Castle County, as well as the effectiveness of the State’s ACT programs in assisting individuals who have significant needs and who have required high-end, high-cost services, the Monitor has recommended that the State further expand the number of ACT teams by two. The ACT teams (and CRISP) have been pivotal in reducing the long-term care population at DPC; this population (which accounts for considerable inpatient bed-days), can further reduced with additional ACT capacity.

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In addition, through exchanges with DSAMH, as well as stakeholders in the corrections and judicial systems, it is clear that there is a need for ACT services among people with serious mental illness who have become caught up in the criminal justice system. Finally, as has been discussed in prior reports, individuals with serious mental illness and co-occurring substance use problems require specialized services, and ACT can be effective in reducing their frequent use of emergency services and psychiatric inpatient beds. For all of the above reasons, the State should work to further expand the number of ACT teams.

686

687 **F. Intensive Care Management**

688 Substantial Compliance.

689 Section III.G.2 of the Agreement required the State to have a total of 4 Intensive Care
690 Management (“ICM”) teams operational by January 1, 2013. As was described in the last
691 report, Delaware has surpassed this target, having 5 ICM teams operational statewide.
692 These teams are currently serving 590 individuals, an increase of 18% over what was
693 reported six months ago. As was discussed in the previous section with reference to
694 ACT, individuals receiving ICM services are, by definition, at elevated risk of mental
695 health crises, including rehospitalization. Nevertheless, they do not account for a
696 significant proportion of psychiatric hospital admissions.

697

698 **G. Case Management**

699 Substantial Compliance.

700 Section III.H.2 requires that by September 1, 2013, the State will train and begin to
701 utilize 3 additional care managers—termed Targeted Care Managers (“TCM”) within the
702 DSAMH system--bringing the total to 18. The State has already met and surpassed this
703 target, having 21 TCMs working in the community and, increasingly, participating in
704 discharge planning at DPC and the IMDs. DSAMH’s longer-range plan is to utilize
705 TCMs as a part of the “front door” for individuals entering public mental health services,
706 with their involvement continuing as needed by the individual.

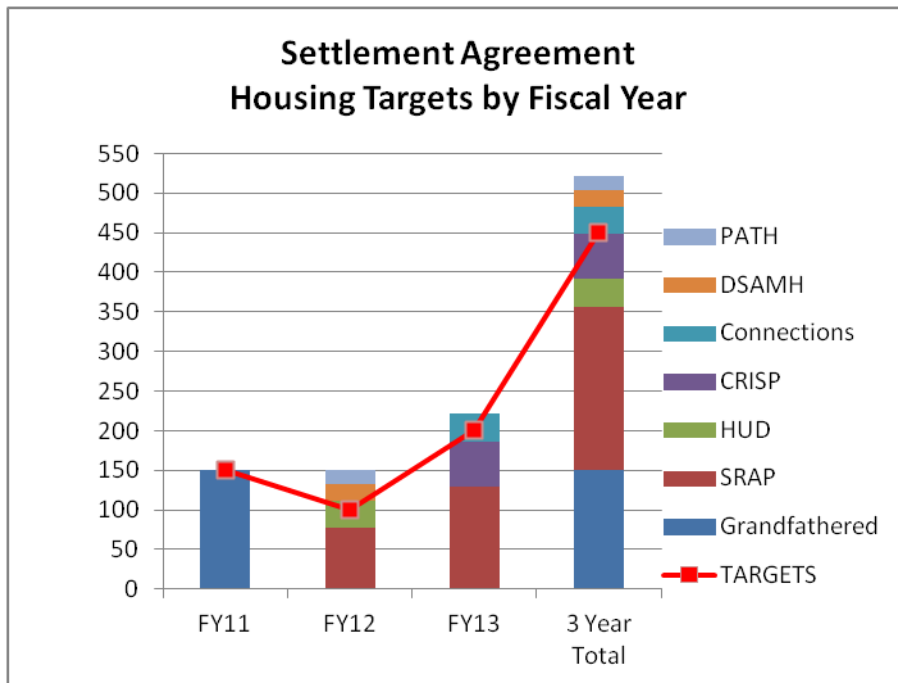
707

708 **H. Supported Housing**

709 Substantial Compliance.

710 Section III.I.3 requires the State to increase housing vouchers, subsidies and bridge
711 funding so that 450 individuals are served as of July 1, 2013. The State continues to do
712 an exemplary job in responding to this provision. The chart below presents data
713 demonstrating that the State is surpassing its target. During the past year, it has created
714 new integrated supported housing for 221 individuals. Of these individuals, 186 received
715 housing supports through state funded programs (SRAP or CRISP). The total number of
716 individuals receiving supported housing in integrated settings (or in semi-integrated
717 supervised apartments, in the case of the 150 individuals who were grandfathered in
718 under the Agreement) is 522. In other words, the State is well on its way to achieving its
719 target for July 1, 2014 of 550 individuals.

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Delaware’s success in its supported housing program goes well beyond its achievement of the numerical targets of the Agreement. Access to integrated housing with needed supports is fundamental to the ADA’s vision of eliminating the social and institutional segregation that have been common among people with serious mental illness.

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The Monitor recently had an opportunity to meet William and Steve, who are served by the Sussex County ACT team and have chosen to share an apartment together. Again, it is worth noting that this area of the State has traditionally been underserved, and thus the availability of ACT and supported housing in the southern counties is an important measure of success. William has a serious mental illness and a history of involvement with the criminal justice system. Steve also has a serious mental illness, in addition to a co-occurring problem with alcohol abuse. He has been in the criminal justice system and has been homeless, sometimes sleeping in shelters.

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Both William and Steve have disabilities and histories that in the past would have made it very likely that they would be relegated to institutions. These individuals now live in a pleasant, modern—and, in keeping with the vision of the ADA—ordinary apartment complex. They are visited by members of their ACT team 2-3 times per week. They have their own bedrooms and share responsibilities in relation to cooking and shopping.

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William and Steve are not yet at their point in recovery where they are fully engaged in outside social activities or employment, but they are doing well living quietly in their own home. Given their histories, that, in itself, is an enormous accomplishment. But there is more to this story that is telling about their success and the success of this

745 DSAMH initiative. Several months back, Steve’s prior roommate left and he was
746 having some problems managing things. Not only was he receiving support from his
747 ACT team, but reportedly neighbors looked in on him to encourage him and ensure
748 that he was doing okay. That interaction with neighbors is mundane, and it is also a
749 testament to how longstanding social barriers affecting people with serious mental
750 illness are beginning to break down.

751

752 **I. Supported Employment**

753 Substantial Compliance.

754 Section III.J.2 of the Agreement requires the state to provide supported employment
755 services to an addition 300 individuals, bringing the total to 400 individuals. There are
756 several levels of employment services provided through the State’s Department of
757 Vocational Rehabilitation (“DVR”). For purposes of evaluating compliance with this
758 provision, supported employment services to individuals with serious and persistent
759 mental illness were counted if an individual had progressed through the DVR system to
760 the point that there was an active plan for vocational rehabilitation or, of course, if the
761 individual was being employed at some level and receiving needed supports. During the
762 past year, a total of 569 individuals met these criteria, thus surpassing the Agreement’s
763 requirements. Of this group, 67 were actively employed at some point during the year.

764 Individuals who are a part of the population targeted by the Agreement commonly have
765 unstable work histories—if they have work histories at all—and their entry into the
766 workforce may be challenged by their levels of impairment, criminal justice histories, and
767 where they stand with respect to their individual recoveries. A substantial number of the
768 individuals receiving supported employment services (99) had a substance abuse issue
769 co-occurring with serious mental illness, presenting an additional set of challenges to
770 employment.

771 Individuals with SPMI who have obtained gainful employment are carrying out critical
772 functions as peer counselors who are employed by the State or by providers (Peer
773 services are discussed below). Others work in mainstream work environments with
774 needed supports. The stories below describe some of the individuals who are
775 beneficiaries of the State’s employment initiatives and the range of their work.

776

777 Jayne lives in her own home with her husband and daughter. She has a long history of
778 treatment for bipolar disorder with psychotic features and has been hospitalized
779 several times. She works as a research assistant for the State, in part, in conjunction
780 with the University of Pennsylvania which is evaluating DSAMH’s CRISP program.
781 In that capacity, she is being certified in human subject research, following the
782 protocol that the university uses for all such research assistants. She sees this as an

783 important addition to her resume. Her CRISP research focuses on consumers’
784 experiences in that program. In addition, Jayne carries out peer satisfaction
785 interviews as a part of DSAMH’s quality assurance program. In both instances, she
786 has leant her first-hand experience as a consumer to assist in the design of the
787 questionnaires being utilized. She finds her work highly rewarding, indicating that
788 “these studies will improve people’s lives in the community.”
789

790 Sandra has been in and out of psychiatric hospitals due to schizophrenia and bipolar
791 disorder. She is served by an ACT team that supports her in living in her own
792 apartment. Sandra describes her life as having been “out of control,” but now works
793 in mainstream employment in a variety of tasks, including assembly work. She
794 reports “I’ve been able to stay out of the hospital for a long time now...and I’m able to
795 go to work.” She regards her current work as transitional, noting “I’m not where I
796 want to be, but I’m not where I was.”
797

798 Todd is a middle-aged man who has hospitalized multiple times for treatment of
799 schizophrenia. For about a year, he has been working in food services at the
800 University of Delaware. He reports that he is often complimented about his work and
801 he takes great pride in leading a productive life. “I am treated like everybody else,”
802 he says, which is an apt description of what the Agreement—and the ADA—intend to
803 achieve for people with disabilities.
804

805 Recommendation:
806

- 807 1. Each of the providers with ACT teams has been able to fund one employment
808 specialist for the agency. DSAMH’s plan has been to focus on bringing these
809 new ACT teams into fidelity with the TMAC model and, as the basic structure
810 and operations become established (which they now are), to ramp up their
811 capacities for supported employment by having one dedicated employment
812 counselor for each team. This is a sensible approach. It is recommended that
813 these positions be established this year.
- 814 2. DSAMH also plans to create a new leadership position within the Division to
815 coordinate employment services throughout its programs. This is a very
816 worthwhile measure and should help the State achieve the significant
817 increases in the number of individuals receiving supported employment
818 services that are required per the Agreement in the coming years.

819

820 **J. Rehabilitation Services**

821 Substantial Compliance.

822 Section III.K.2 of the Agreement requires the State to provide rehabilitation services to
823 an additional 500 individuals by July 1, 2013, bringing the total requirement to 600.
824 Rehabilitation services comprise an array of activities, such as education, substance abuse
825 treatment, and recreational activities. Some of these components are not well defined in
826 the State’s data systems. Furthermore, without sufficient intensity of a rehabilitative
827 service, the meaning is dubious (for instance, crediting a single recreational encounter
828 with an individual towards the goal of 600). For purposes of evaluating the State’s
829 compliance with this provision, an individual was counted if:

- 830 (a) Psychosocial Rehabilitative Services, Psychosocial Group Services, or Family
831 Psychosocial Education was provided at least twice per month for at least 6
832 months. 439 individuals met this criterion;
- 833 (b) Some level of substance abuse service for a co-occurring disorder was
834 provided during the year. 929 individuals met this criterion; or
- 835 (c) There was ongoing participation as a peer volunteer. 10 individuals met this
836 criterion.

837 The State is surpassing its requirements with respect to Rehabilitation Services.

838

839 **K. Family and Peer Supports**

840 Substantial Compliance.

841 Section III.L.2 of the Agreement requires the State to provide family or peer supports to
842 an additional 250 individuals, bringing the total number receiving this service to 500. As
843 has been noted in previous reports, an impressive peer movement has evolved in the
844 State, whereby individuals who, themselves, have mental illness provide vital services to
845 members of the population covered by the Agreement. These services range from
846 supports to inpatient at DPC (where peers meet with individuals and provide “Hope”
847 bags containing information and essentials upon admission and discharge), to
848 socialization and support in consumer advocacy, to participation on ACT teams. The
849 State has surpassed its requirements with respect to this provision, providing Family and
850 Peer Supports to approximately 600 individuals.

851

852 **L. Transition Planning**

853 Substantial Compliance.

854 Section IV.A sets forth requirements for person-centered recovery-oriented discharge
855 planning, including the requirement that individuals be assessed from the perspective
856 that, with sufficient supports and services, they can live in integrated community settings.
857 Fulfillment of this provision requires not only procedural changes, but significant
858 changes in how the needs of individuals are conceptualized and how their preferences are
859 accommodated.

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

871

872 **IV. Summary**

873 Delaware continues to make significant progress toward fulfillment of its obligations
874 under the Agreement. As is delineated above, it has met or surpassed the benchmarks
875 contained in the Agreement for each of the measures that have come due. The State
876 continues to move forward on measures to address the structural issues—data,
877 involvement of the court system, and care management—that are necessary for it to
878 sustain its accomplishments through the duration of the Agreement and beyond. The
879 leadership in the State, at DHSS, and DSAMH merit praise for their efforts to advance
880 the opportunities for Delawareans with SPMI and other disabilities.

881

882

883 Robert Bernstein, Ph.D.

884 Court Monitor