Third Progress Report on

Implementation of the Settlement Agreement

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

July, 2015

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Substance Abuse and Mental Health

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Dear Citizens of Delaware,

As we approach the end of the fourth year of implementation of the Settlement Agreement between the U.S. Department of Justice (USDOJ) and the State of Delaware, we are pleased to report that the State has made significant progress in reforming the mental health system and in meeting the benchmarks established in the five-year agreement signed July 6, 2011. For the Department of Health and Social Services (DHSS) and the State of Delaware, the progress we have made is not solely about meeting legal objectives laid out in the agreement. This is about serving our neighbors, friends and family members with serious and persistent mental illness so they can live ordinary lives in the community with the services and supports they need.

As this report demonstrates, DHSS and its Division of Substance Abuse and Mental Health (DSAMH) continue to develop and enhance community-based mental health services and supports. The Settlement Agreement specified five target areas – crisis services, intensive support services, housing, supported employment and rehabilitation services, and family and peer supports. In this report, you will read about the tremendous progress made in those areas and the challenges that remain. Across the state, working with our partners, we have reduced long-term stays in psychiatric hospitals; built 24/7 Mobile Crisis Intervention Teams that can respond anywhere in the state in less than hour; opened a 24/7 crisis walk-in center in Ellendale to serve the southern part of the state, with a similar center opening in New Castle County later this year; developed treatment and case management teams to serve people in need of intensive services; revamped our housing programs so more individuals have affordable and safe places to live; advanced employment opportunities to increase individuals' ability to thrive and support themselves; built a strong family and peer support system to aid individuals in their recoveries; and, for the first time in decades, reviewed and modernized Delaware's civil mental health laws. We thank the consumers, their families and their advocates for their ongoing work alongside our staff and providers. We also thank all the other stakeholders who continue to work with passion, dedication and commitment to carry out these changes with us.

Every day, we see the benefits of the robust community-based system we are building when individuals with serious and persistent mental illness are able to engage in a full community life, to find meaningful employment, to live in their own home with appropriate supports, and to share their gifts with others and vice-versa. Delaware is a stronger and more vibrant state when we benefit from the talents and skills of all of our residents.

While we continue to make progress, there are still challenges to overcome as we embed inclusion and the benefits of diversity as core values in our state. Our expectation is that the community-based mental health system we are building will serve individuals with serious and persistent mental illness for decades to come and will be a lasting testament to the work of the many consumers and stakeholders involved.
We encourage you to contact us with questions, concerns or comments.

Sincerely,

Rita Landgraf
Cabinet Secretary
Delaware Department of Health and Social Services

Dr. Gerard Gallucci
Acting Director
Division of Substance Abuse and Mental Health

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SECTION I - OVERVIEW

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

The Settlement Agreement is broken down into the following areas:

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

In *Section V. Quality Assurance and Performance Improvement F. Reporting, Page 19* the Settlement Agreement addresses the requirements of the State to publish an annual report:
"*The State will publish an annual report identifying:*

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

This is the Third Annual Report issued by the Department of Health and Social Services (DHSS) on behalf of the State of Delaware. The first report was issued in May 2013 that covered the first 18 months of the Settlement Agreement. The Second Annual Report was issued December 15, 2013.

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

The second annual report was based on the third and fourth reports issued by the Court Monitor dated March 8, 2013, and September 24, 2013, and the overall accomplishments in year two of the Settlement Agreement. Per Section VI (Monitor and Monitoring) of the Settlement Agreement, the USDOJ appointed a Court Monitor to oversee the implementation.

The Third Annual Progress Report is based on actions by the Department of Health and Social Services (DHSS) and the Division of Substance Abuse and Mental Health (DSAMH). DHSS and its divisions, which have clients who are part of the Settlement Agreement, continue to strengthen the foundation of the new mental health system and implement programs and procedures that support the concept of community service delivery to persons with a mental health disability.

There are many successes that are a direct result of the Settlement Agreement, in fact too many on which to report. The State has chosen three to highlight:

1. The reduction of bed days for clients who have been institutionalized for a long term;
2. The creation of new housing opportunities for clients who otherwise would have been products of long-term institutionalization.
3. The success of the HJR 17 Committee and its subcommittees;
4. The creation of the PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) Program, a joint venture between the Division of Medicaid and Medical Assistance (DMMA) and the Division of Substance Abuse and Mental Health (DSAMH); and
5. The Peer Movement in Delaware, which includes meeting the initiative of Governor Markell for the State to advance employment opportunities for persons with disabilities.

Additionally, this report will synthesize the results of the State meeting the targets as defined in the Settlement Agreement and described in the Court Monitor Reports for FY14 dated May 19, 2014, and December 15, 2014. (See Appendix I for the results of the FY14 Targets.) The Monitor's reports provide a status of the Settlement Agreement for the State in FY14 from July 1, 2013, to June 30, 2014.
This report includes:

- Section I: Introduction and Overview of the Settlement Agreement;
- Section II – Olmstead and the State Plan
- Section III: Highlights of the Year, and
- Appendix I: Status of the Settlement Agreement Targets for FY14
- Appendix II: Final Report of the HJR 17 Civil Mental Health Law Study Group

SECTION II – OLMSTEAD AND THE STATE OLMSTEAD PLAN

Delaware has a functional and ongoing "*Olmstead* Plan." Taking its name from the landmark Supreme Court case *Olmstead v. L.C.*, 527 U.S. 581 (1999), an *Olmstead* Plan sets out a State's strategy for identifying and transitioning individuals with disabilities to the most integrated setting appropriate for their needs.

As established by the courts, the central requirements of a functioning *Olmstead* Plan can be summarized as follows: (1) an "assurance" or "commitment" to "take all reasonable steps" so that there will be "ongoing progress" toward community placement in the future; (2) the commitment must be "communicated in some manner"; and (3) the State must be "held accountable." *See Frederick L. v. Department of Public Welfare*, 2004 WL 1945565, at *7 (E.D. Pa. Sept. 1, 2004). *See also Day v. District of Columbia*, 894 F.Supp.2d 1, 6 (D. D.C. 2012).

The United States Department of Justice ("USDOJ") has described *Olmstead* Plans as follows:
"An Olmstead plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan." "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C." A copy of the Statement can be found at http://www.ada.gov/olmstead/q&a_olmstead.htm

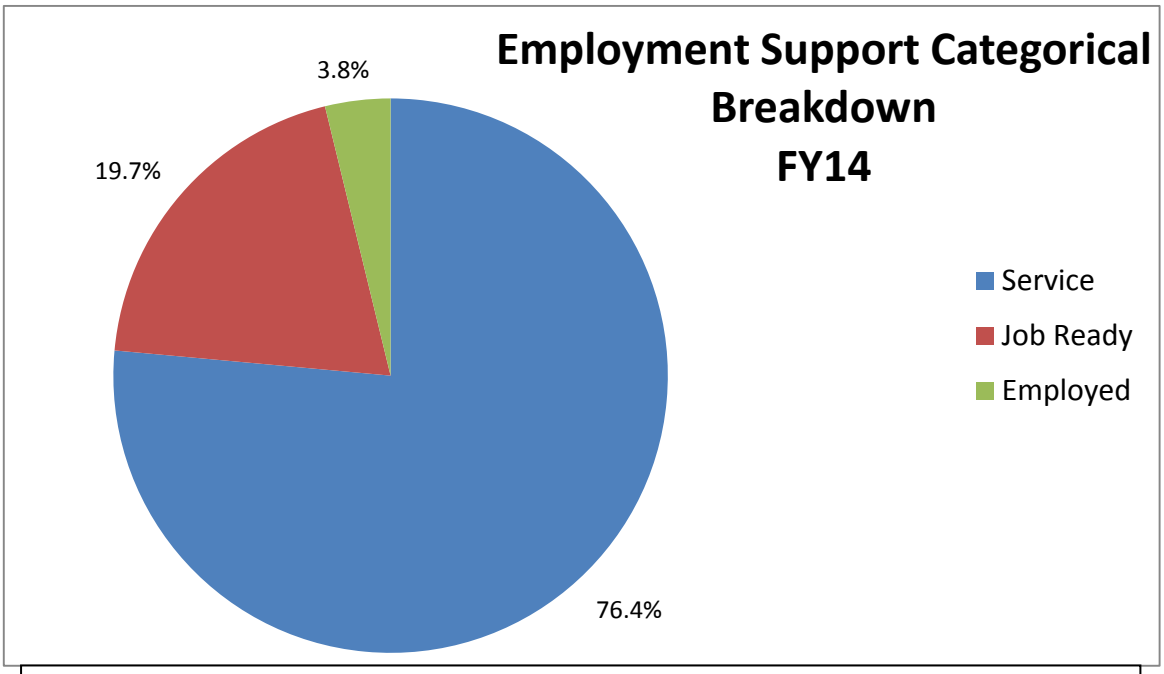
As made clear by the USDOJ, there is not a "one-size-fits-all" approach to *Olmstead* Plans. Rather, each State has the discretion to develop a plan which best fits the needs and resources specific to its population. The State of Delaware presently maintains a functioning *Olmstead* Plan that meets all of the above criteria. Additionally, the State's Plan has yielded measurable results that show how individuals who have been in inpatient settings at the inception of the Settlement Agreement have been moved into more integrated settings.

Within the body of this report are several examples of integration and increase in community supports. For example the discussion on the "Reduction of Long-Term Bed Days" includes a chart on Delaware Psycharitic Center (DPC) Length of Stay (point in time data) for all clients receiving inpatient services in the hospital.

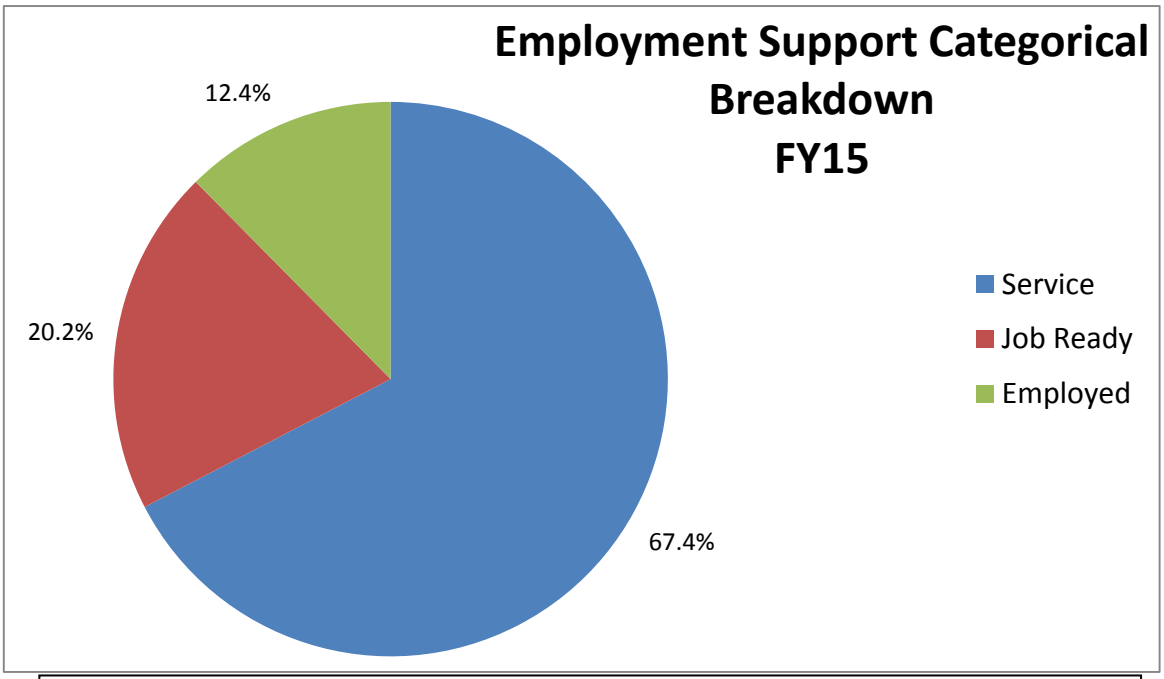
Following the "Reduction of Bed Day Discussion" is a discussion about New State Funded Housing Programs for clients with SPMI. The Settlement Agreement called for the State to fund 650 housing units (150 were grandfathered in at the time the Settlement Agreement was signed; 500 are new housing units funded out of money designated by the State). The State has exceeded the required number of new housing units as seen in the chart imbedded in the discussion "Revamping the DSAMH-Funded Housing Programs."

In addition to the State's success in transitioning long-term clients from DPC to the community and reducing the length and frequency of psychiatric inpatient treatment, the state also continues to provide comprehensive support services to individuals with SPMI in the community. Delaware is committed to ensuring that all Delawareans are able to live full and meaningful lives in the community.

One of the aforementioned community-based services is supported employment. The pie charts below highlights the employment support breakdown among consumers:



Supportive Employment is a key piece to integrating clients into the community. Employment is an opportunity for a client to experience value and success through his/her own achievement and service = a worker among workers. ***(Chart provided by DSAMH).***



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Another example of providing services in the community are the clinical services offered by the ACT Teams. The ACT Teams are providing community services throughout the State. The table below indicates that as of March 2015 the number of ACT Teams in each county and the average number of clients served:

Number of ACT Teams and Clients per Team FY15

	FY14 Avg	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
NCC Teams	7.3	11	11	11	11	11	11	11	11	11
NCC Clients	693.4	1057	1084	1102	1106	1121	1115	1122	1098	1078
NCC Clients/Team	94.99	96.09	98.55	100.18	100.55	101.91	101.36	102.00	99.82	98.00
Kent Teams	2.1	3	3	3	3	3	3	3	3	3
Kent Clients	172.25	277	289	282	285	286	288	293	289	292
Kent Clients/Team	82	92.33	96.33	94.00	95.00	95.33	96.00	97.67	96.33	97.33
Sussex Teams	2	2	2	2	2	2	2	2	2	2
Sussex Clients	163.2	162	169	171	173	174	172	168	167	163
Sussex Clients/Team	81.6	81.00	84.50	85.50	86.50	87.00	86.00	84.00	83.50	81.50
Overall	90.25	93.50	96.38	97.19	97.75	98.81	98.44	98.94	97.13	95.81

DSAMH chart data maintained daily and reported for data review monthly March2015

In addition to the ACT Teams providing services in the community the Targeted Care Managers (TCM), a case management service used to shepherd a client through the available services before s/he is admitted to an ACT Team is also serving clients throughout the State. The table below demonstrates the number of clients on a case load and the number of persons who are employed to provide TCM services:

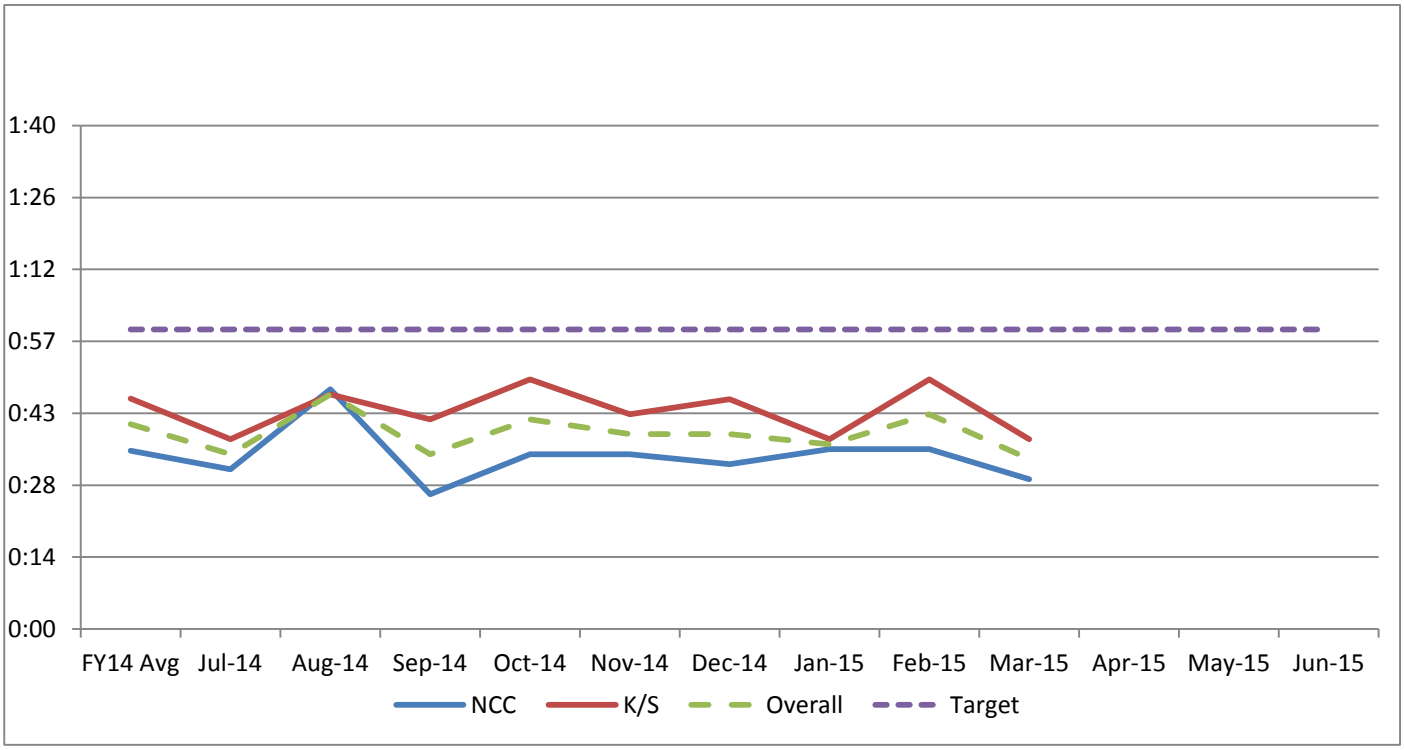
Average Case Load Per Target Care Manager

		FY14 Avg	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
State	**# of Clients**	61.1	57	62	54	55	58	60	57	61	62
	# of CMs	5	5	5	5	5	5	5	5	5	5
	Avg Clients/CM	12.2	11.4	12.4	10.8	11.0	11.6	12.0	11.4	12.2	12.4
RI - NCC	**# of Clients**	123.5	136	148	129	123	101	84	91	101	109
	# of CMs	9	9	9	9	9	9	9	9	9	9
	Avg Clients/CM	13.7	15.1	16.4	14.3	13.7	11.2	9.3	10.1	11.2	12.1
RI - Ellendale	**# of Clients**	104.7	134	135	122	130	116	116	116	119	130
	# of CMs	11	11	11	11	11	11	11	11	11	11
	Avg Clients/CM	9.5	12.2	12.3	11.1	11.8	10.5	10.5	10.5	10.8	11.8
Totals	**# of Clients**	289.3	327	345	305	308	275	260	264	281	301
	# of CMs	25	25	25	25	25	25	25	25	25	25
	Avg Clients/CM	11.6	13.08	13.8	12.2	12.32	11	10.4	10.56	11.24	12.04

DSAMH chart data maintained daily and reported for data review monthly March 2015

As a final example of community-based services, the State expanded its Mobile Crisis Teams to provide 24/7 services throughout the State. When a citizen is in crisis s/he can call the Mobile Crisis Teams at any time. The Teams not only provide telephone consultation but also will go to the client's home and if necessary ensure that the client is transported to services at the RRC in Ellendale or into a psychiatric hospital depending on the location of the client and the availability of a bed. Below is a graph that shows the Average Response Time for the Mobile Crisis Team:

Mobile Crisis Average Crisis Response Time Calls only FY15



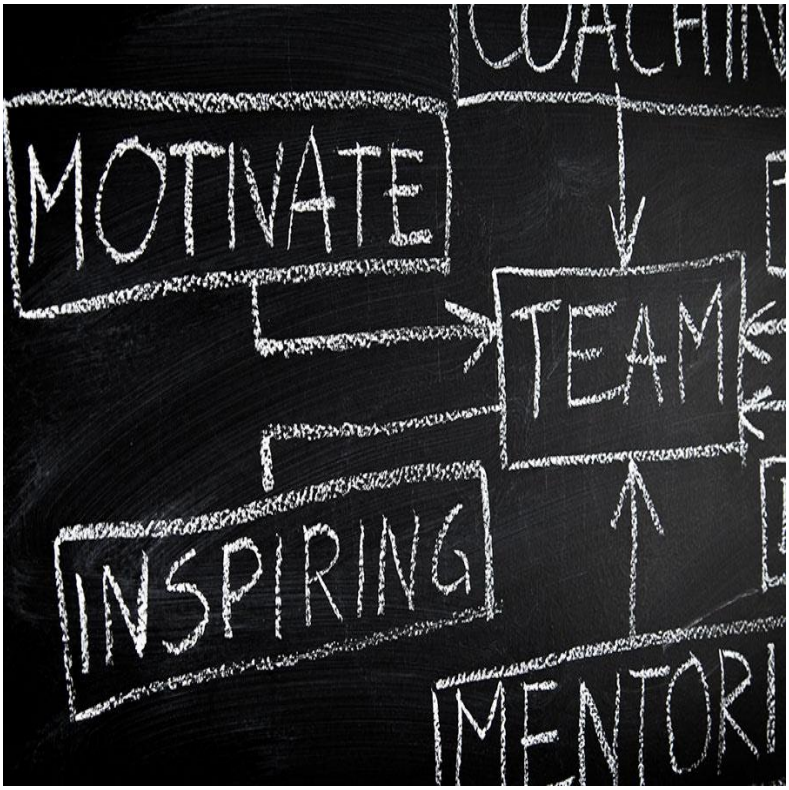
DSAMH data collected monthly from Mobile Crisis Teams, 2015

Reduction of Bed Days

The Settlement Agreement requires that for FY14 the "the number of annual State-funded patient days in acute settings in the State will be reduced by 30% from the State's baseline on the effective date of the Settlement Agreement …" Section III Implementation Timeline D. Crisis Stabilization Services para 3 page 11. It goes on to say that in FY16 the number be reduced even more to 50% of the baseline.

The focus of bed day reduction is both for long-term reduction as well as acute bed days. In both cases the State has been successful in reducing bed days.

In addition to collecting its own data, the State has also been working with researchers from the University of Pennsylvania, Perelman School of Medicine to help it track and understand psychiatric inpatient bed usage in Delaware.



University of Pennsylvania Cohort Analysis

Center for Mental Health and Services Research

The University of Pennsylvania, Perelman School of Medicine, Center for Mental Health Policy and Services Research, has performed data analysis for DSAMH for several years. The research team implemented a study design that tracks psychiatric inpatient bed usage based upon a "cohort" design. An individual joins a cohort based upon the first year he or she had outpatient or inpatient psychiatric treatment that met the criteria of serious and persistent mental illness. The analysis below shows that in "Year 2," 1551 individuals that were SPMI had an inpatient admission of the 2503 individuals in that cohort. The University of Penn research team then followed each annual cohort to study whether the use of psychiatric inpatient treatment changed once they are "known" to Delaware's mental health system.

The number of acute care community psychiatric bed days by year by each annual cohort and by all previous or subsequent cohorts, beginning with FY11 to FY14 is shown below. As described, each cohort represents a group of newly identified clients using public sector mental health services. What the numbers in Table 1 show is a dramatic reduction in inpatient psychiatric bed use once an individual is identified to the State as requiring mental health services.

Table 1 includes all DSAMH (uninsured) and MA funded clients. It begins with 2010-2011. The analysis shows that in 2010/2011, of the 2503 individuals (cohort 2) that met target population criteria, 1551 people used 13754 acute care inpatient psychiatric days. In the three years that followed, individuals from this cohort of 2503 used 5780 days in 2011/2012, 3857 in 2012/2013 and 2736 in 2013-2014. This represents a reduction over 3 years of 80%. In the two year trajectory followed by cohort 3, bed days go from 11678 to 3357 (row 2) which is a 71% reduction in just 2 years.

See Table 1 below:

TPPL Cohort Chart- Table 1

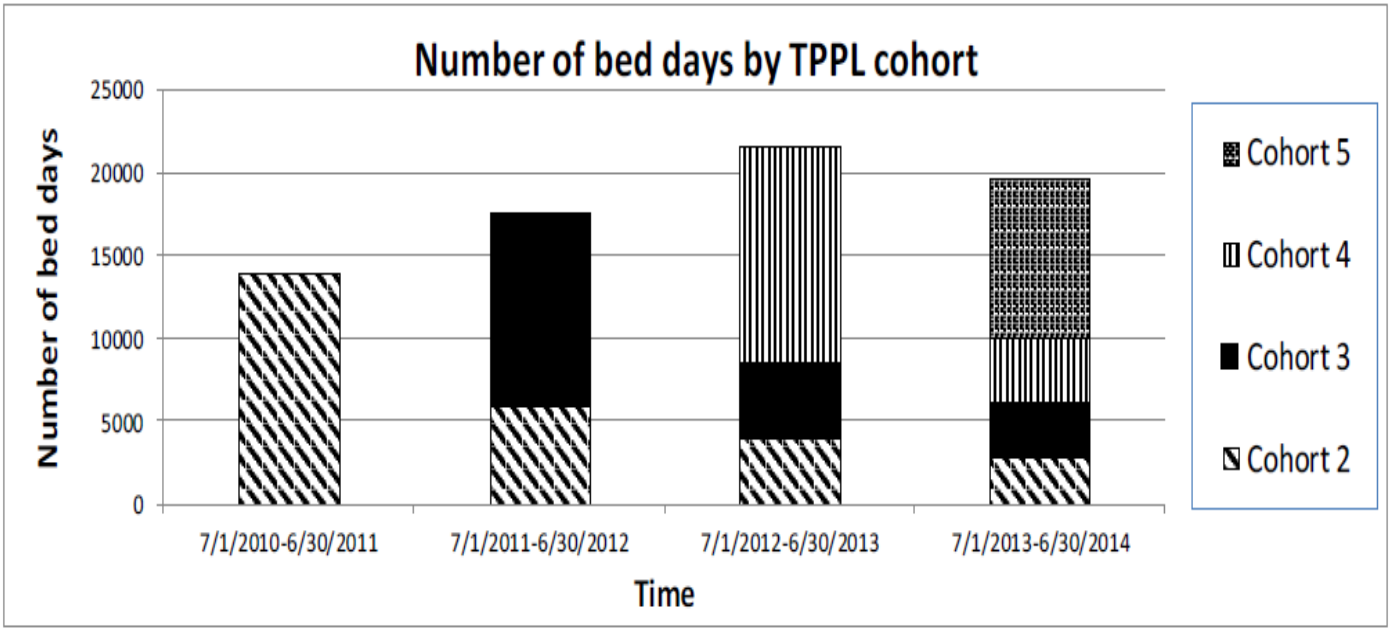
TPPL cohort	Total bed-days (n)			
	7/1/2010-6/30/2011	7/1/2011-6/30/2012	7/1/2012-6/30/2013	7/1/2013-6/30/2014
Cohort 2 (n=2503)	13754(1551)	5780 (443)	3857 (286)	2736 (213)
Cohort 3 (n=2548)		11678 (1309)	4542(365)	3357 (207)
Cohort 4 (n= 2357)			13135 (1364)	3829 (305)
Cohort 5 (n=2324)				9639 (1012)
Total inpatient days	13754	17458	21534	19561
Users (Total number of inpatient users)	1551	1752	2015	1737
User mean (Total inpatient days/Total # of inpatient users)	8.87	9.96	10.69	11.26
Total number of episodes	2079	2455	2872	2420
Episode mean (Total inpatient days/Total # of episodes)	6.62	7.11	7.49	8.08

* Does not include n=5869 from Cohort 1

Perelman School of Medicine University of Pennsylvania, 2015

There has been an annual decrease in the inpatient community psychiatric hospital days by cohort when they enter the analysis. However, those in the target group from previous years continue to contribute to the system or "total days", although their contribution diminishes over time. Overall, the number of inpatient acute care days (excluding DPC acute units) increases from 13754 to 19561 over the 4 year period with approximately half of the days coming from previous cohorts 2, 3, and 4-Table 1 - column 5). See Figure 1 below:

Number of bed days by TPPL cohort- Figure 1



Perelman School of Medicine University of Pennsylvania, 2015

Figure 1 (above) shows a decrease in both the total number of SPMI individuals annually who meet cohort criteria (2503 to 2324) as well as a decrease in the annual number of inpatient days they contribute to overall psychiatric hospitalization (13754 days for cohort 2 in 2010; 9639 days by cohort 5 in 2013-2014). Thus total inpatient days (row 5) begins to show a decrease beginning in 2014 in total annual days of the target population as both the number of individuals in the new cohorts decrease as well as the number of bed days of individuals in other cohorts (row 6, inpatient users).

It is important to note that the analysis in Figure 1 does not include bed days in the state hospital where admissions of an acute care nature (less than 14 days) have increased somewhat as the number of long term beds have been reduced. Initial analysis shows that most of these admissions with respect to length of stay are considerably longer than the community hospital which is on average 6-7 DAYS per episode. A preliminary analysis shows that acute days in DPC increased by about 125 days between 2011 and 2014, however; overall state hospital days will go down considerably.

An analysis of this data also shows that approximately 66% of each year's inpatient users do not experience another acute care psychiatric inpatient episode over 4 years. Thus 50% of inpatient bed days in the community acute care hospitals of individuals with serious mental illness are associated with first time users who experience their crisis episode. These individuals are generally not in treatment in the public system which means the MH system is not aware of their unmet needs. Most are coming from the Medicaid program. Once an individual is admitted to the system through use of the acute care hospital, their subsequent crisis use is dramatically reduced.

Reducing acute care bed days, based on the analysis, requires the ability to divert first time users of psychiatric inpatient care; reduce even further the average length of stay in the community hospitals of 6 days per admission or reduce admissions of those individuals who experience a second and third episode given that half of the bed days are being used by those in previous cohort. "

Reduction of Long-Term Hospital Stays

As highlighted in other parts of this Annual Report, the Settlement Agreement addressed a complete overhaul of the mental health system in Delaware. The targets specifically address enhancing community mental health services, providing integrated housing, supportive employment and reducing the number of bed days that a person spends in a psychiatric hospital.

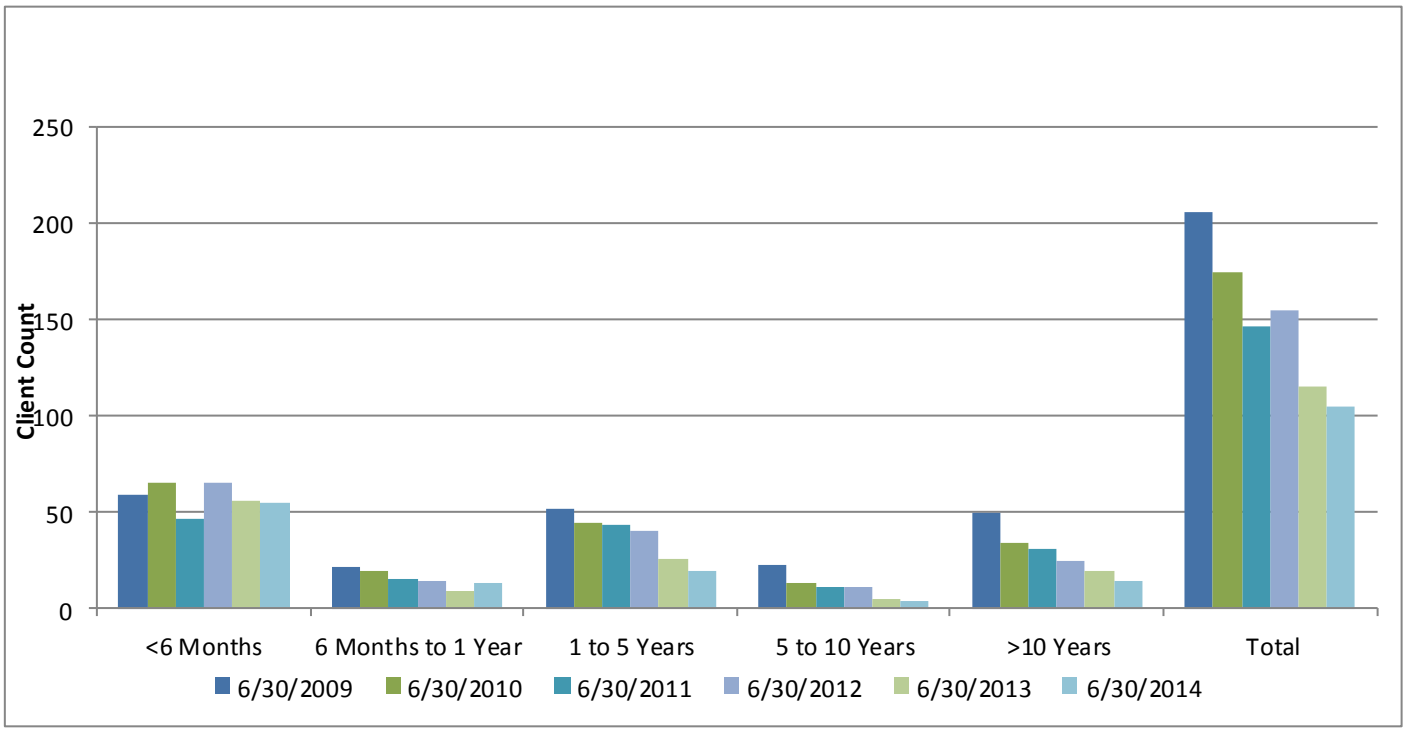
This section of the report focuses on the successes of reducing the number of days a person spends in the hospital and the reduction of long-term hospitalization. Specifically addressing the philosophy of the Olmstead decision – reducing long-term hospitalization and providing services and housing in an integrated setting in the community.

As you will see, due to the continued work of the State, along with community providers, there has been great success with regard to reducing long-term hospital stays. This accomplishment is a major portion of the Settlement Agreement. (It is important to note that long-term bed days are only in DPC – the IMDs do not keep a person typically after seven days.)

The chart below (Chart A) is a "point-in-time" demonstration of the number of persons who were hospitalized in Delaware Psychiatric Center from 6/30/2009 through 6/30/2014. The chart is broken into lengths of stay from less than 6 months, 6 months to a year, 1 to 5 years, 5 to 10 years and more than 10 years.

One of the most important statistics featured in the chart is the dramatic drop in long-term stays in the categories 1 to 5 years, 5 to 10 years and more than 10 years. This is an indication of the successful efforts of the State and the community mental health providers to deinstitutionalize clients and provide robust services in the community.

DPC Point in Time LOS Breakdown (All Clients) 6/30/2009 to 6/30/2014 (Chart A)



Time-Frame	6/30/2009	6/30/2010	6/30/2011	6/30/2012	6/30/2013	6/30/2014	% Change from 6/30/2009
<6 Months	59	65	47	65	56	55	6.78%
6 Months to 1 Year	22	19	15	14	9	13	40.91%
1 to 5 Years	52	44	43	40	26	19	63.46%
5 to 10 Years	23	13	11	11	5	4	82.61%
>10 Years	50	34	31	25	19	14	72.00%
Total	206	175	147	155	115	105	49.03%

Notes: *The data extract from PMIS was as of 3/26/2015. **All clients are included in the above counts. Diagnostic designation as SPMI was not considered. ***Due to increasing Lengths of Stay as clients remain at DPC, a point-in-time census was used to help calculate the LOS as of each presented date. For example, a client counted in the "<6 Months" category as of 6/30/2009 could have been included in another category, if that client remained at DPC, as of 6/30/2010

DSAMH instituted a number of initiatives in the first year of the Settlement Agreement to successfully move clients from a long-term hospitalization in DPC to community living. Two that were specifically for discharging individuals into the community were:

Barrier Buster Meetings: The purpose of the Barrier Buster meetings was to identify barriers that prevented a long-term patient living in DPC to move into the community. The weekly meetings were hosted by DSAMH with attendance by the service providers, staff from DPC and DHSS staff. Over an 18-month period, the weekly meetings successfully orchestrated moving 35 long-term patients into community settings.

CRISP (Community Re-Integration Support Program): In keeping with the spirit of the Olmstead decision as it relates to community supports, DSAMH developed an intensive community treatment program for individuals who were discharged from long-term hospitalization. The CRISP teams provide intensive services to the clients that include access to housing, employment, clinical services, medications and other services as needed. Additionally, one service provider provides a crisis bed, which is an alternative to hospitalization.

Other early interventions were established to divert clients from a hospitalization and serve clients with a mental health crisis in a community setting:

Mobile Crisis Intervention Teams (MCIS): The number of 24/7 Mobile Crisis Teams has doubled. Prior to the Settlement Agreement, the Mobile Crisis Team based in Sussex County did not work 24/7. The team that was based in New Castle County did work 24/7. MCIS teams now offer 24/7 service statewide to the citizens of Delaware. This improvement meets another target as defined by the Settlement Agreement. The requirement for each team is to respond to a crisis within one hour of the call to the hotline. The State achieved its goal in FY12 and has been meeting the goal each year since.

In Sussex County, the Mobile Crisis Team has successfully diverted a majority of the crisis calls from a hospitalization either by de-escalating the situation on the phone or in the home, or by taking the client to the Recovery Response Center (RRC) in Ellendale where the client has 23 hours in which to work with staff to manage the crisis and to determine next steps.

Recovery Response Center (RRC): The Recovery Response Center was opened in September 2012. The target for a crisis walk-in center states "by July 1, 2012 the State will make best efforts to make operational one crisis walk-in center in Ellendale to serve the southern region of the State. The crisis walk-in center in Ellendale shall be operational no later than September 1, 2012." Page 11 Section III Para. C. Crisis Walk-in Centers #1.

The RRC manages six recliners that are used for serving clients in crisis for up to 23 hours. The 23-hour stay provides the client time to de-escalate and for the on-site psychiatrist and the client to determine the next steps. The next steps could be admission to a hospital for further mental health services, or release to the community, with a mental health plan that meets the immediate needs of the crisis and provides for the client to reach out to his/her service provider.

The 23-hour observation fits well with the revised State Commitment Laws. The State Commitment Laws clearly state that the first 24 hours of an involuntary commitment must be a time for observation and if during or at the 24th hour it is determined by the Psychiatrist that the client does not have to be institutionalized and there are other steps that can be taken in the community, it is recommended that the physician and the client develop a plan for the client to receive appropriate services in the community.

As of March 2015, the RRC in Ellendale has diverted an average of 76.43 percent of its clients from hospitalization (Score Card Trending March 2015) for FY15 the total diversion for all of FY14 is 78.73 percent (Score Card Trending March 2015).

RRC Coming to NCC: New Castle County has had a walk-in crisis service for several years provided by Christiana Care Health Systems in Wilmington. In 2014, the State issued a Request for Proposal (RFP) to replicate the Sussex County RRC in New Castle County.

The State has awarded a contract to Recovery Innovations to operate a recovery center in New Castle. The RRC New Castle County will be open by the end of 2015.

The change in the community services has also affected the success of hospital diversion. Below are additional programs that the state has put into operation to better serve clients in the community. (See discussion in Section II on State Olmstead Plan implementation.)

Assertive Community Treatment Teams (ACT): The Assertive Community Treatment Teams (ACT) replaced the Community Continuum of Care Plan (CCCP) Teams. The premise of the ACT teams is that mental health services are delivered in the community instead of in an office setting. Typically, the ACT Team consists of 10 members, in addition to two persons, an administrative member and the psychiatrist for the team. Up to 100 clients are assigned to a team. The ACT team is responsible for 24/7 services and must respond to a client when s/he is in a crisis regardless of the time of day. By providing 24/7 services, the client has less of a chance to be admitted to a hospital and more of a chance for the crisis to be de-escalated in the home or at the RRC. As of this writing, there are 16 ACT teams throughout the state.

Intensive Case Management (ICM): The ICM Teams provide intermediate services. Typically, a team of 10, plus the administrator and psychiatrist, serve 200 clients. The services are less intensive than ACT and the clients are able to negotiate the world in a more independent fashion. The clients are able to access the same crisis services, housing and employment as the ACT clients. As of this writing there is one ICM team in the state.

Crisis Apartments: The Settlement Agreement required that Delaware establish Crisis Apartments, one apartment in New Castle County (two beds) and one serving both Kent and Sussex Counties (two beds). The purpose of the Crisis Apartments is to provide a client an opportunity to locate to a safe apartment (not a hospital) that provides a stable environment for up to seven days so the client can work through the crisis with the help of his/her ACT team. The Crisis Apartment provides 24/7 supervision and the ACT team has daily access.

The State expanded the number of beds for the Crisis Apartments to four in New Castle County and four serving downstate, for a total of 8 beds. The apartments are utilized 54 percent of the time, and in some instances have up to 10-day stays so clients can stabilize and determine next steps for housing and other services. A typical stay is from three to seven days.

Overall, the State continues to evolve by evaluating existing services and when necessary move to better models. The emphasis is on providing the best services to the client where and when s/he is in need. Diversion has been a success both for the clients in acute care and in long-term care.

Risk Management: The Department of Health and Social Services has a Department-wide risk management plan, which cascades into a division by division risk management plan. The Settlement Agreement requires that the State have a fully functioning Risk Management Plan, which includes periodic training of DSAMH service providers who also must abide by the State Risk Management Plan. The structure of a Plan is to be fully functioning at the Division level and report to the Department level as required, based on the severity of the incident and the negligence of the service provider.

DSAMH has completely revised its Risk Management Plan by soliciting outside assistance from a consultant who has refined the already existing Plan and ensured that the new plan is coordinated with the requirements of CMS (the clients of DSAMH typically receive services funded by Medicaid and, thus, the Risk Management Plan must meet CMS standards).

Revamping the DSAMH-Funded Housing Programs

Prior to the implementation of the Settlement Agreement, the Division of Substance Abuse and Mental Health (DSAMH) provided funds to the service providers to provide both clinical and minimal housing services for the clients. The housing was either in the form of a group home or supervised apartments. The Settlement Agreement changed the way DSAMH addressed the housing needs for clients by requiring the State to fund 650 housing units for clients with SPMI and to have DSAMH take the lead in managing and/or administering the housing.

Before the Settlement Agreement, the service provider provided housing only to their clients in both the group homes and supervised apartments. For instance, if a person was in need of housing the person might have to change service providers to be housed. Clients in the supervised apartments received services at the apartment and in the community by the same service provider. Overall, this system was unacceptable for the supervised apartments because there was an uneven distribution of housing between the service providers.

The group homes were also managed by the service providers. Clients who were admitted to a group home received all their services there and did not go into the community for clinical services.

After the implementation of the Settlement Agreement, DSAMH determined that a new supervised housing program should be managed by an outside property management company and all DSAMH clients, regardless of their service provider, should have equal opportunity to apply and be accepted into housing. The group home model did not change after the implementation of the settlement Agreement.

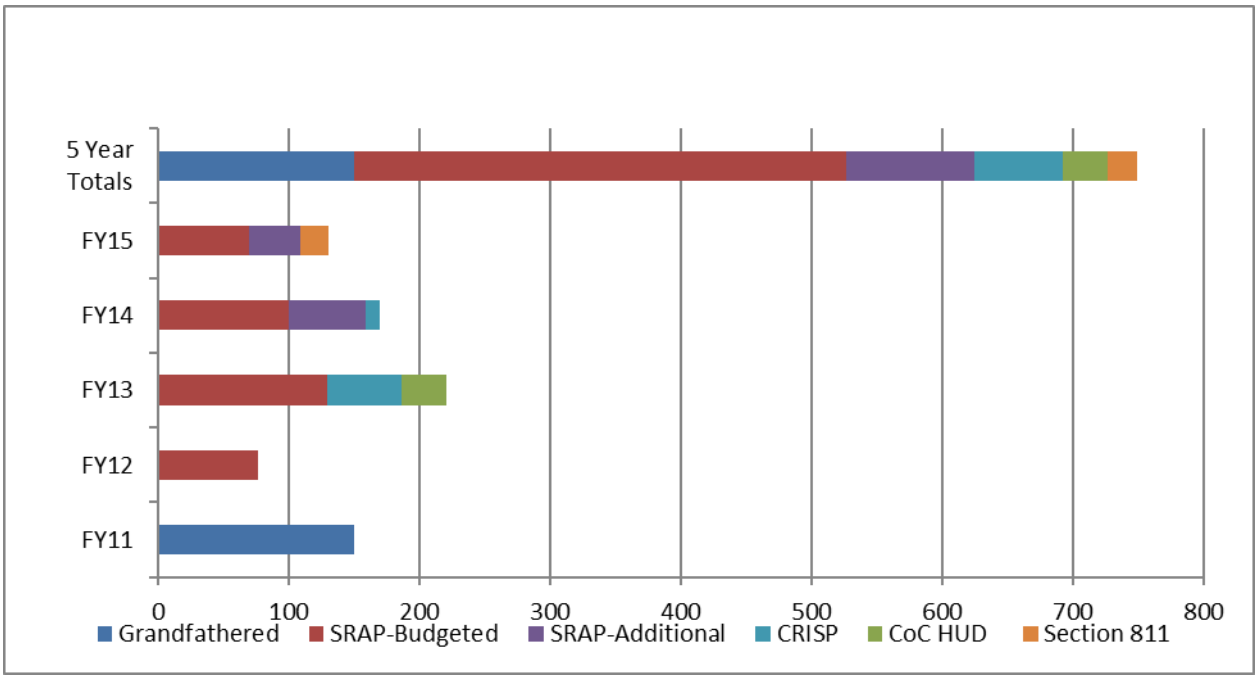
By the end of FY15, one year before the end of the Settlement Agreement, the State will have funded 650 integrated housing units (the target for housing). The State will have met that goal by July 1, 2015. In fact, it will have exceeded the goal by 93 units.

In general, the State has funded several different types of housing programs which has provided a variety of opportunities for clients in various degrees of recovery and ability to live independently in the community. This has made the system much more unified, and DSAMH now has strong partnerships with community providers to provide housing services.

The housing options range from supervised apartments to independent living through the State Rental Assistance (SRAP) program or the Section 811 project-based rental subsidy program. As part of the supervised apartment program (SAP), there are short- and long-term housing options, resource beds, and transitional housing. The State provides housing funding for clients who are in the CRISP (Community Re-Integration Support Program) so the client can live alone or with up to three other persons depending on the interest and the level of need for the client. The State also provides funding for Crisis Apartments, which is a requirement of the Settlement Agreement, as well as a crisis apartment for the CRISP clients (not required by the Settlement Agreement). In each of the housing scenarios, the common factor is the ability of the client to live independently. The housing options are based on the client's needs, the client housing choice and availability.

Chart B (below) is a snapshot of the housing numbers:

Settlement Agreement - Housing Targets FY11 to FY15 (Chart B)



Type	FY11	FY12	FY13	FY14	FY15	5 Year Totals
Grandfathered	150	0	0	0	0	150
SRAP-Budgeted	0	77	130	100	70	377
SRAP-Additional	0	0	0	59	39	98
CRISP	0	0	56	11	0	67
CoC HUD	0	0	35	0	0	35
Section 811	0	0	0	0	22	22
ACTUAL TOTAL	**150**	**77**	**221**	**170**	**131**	**749**
TARGETS	**150**	**100**	**200**	**100**	**100**	**650**

Notes*:* Date of chart April 2015 *SRAP numbers change according to the amount of money available, which is based on a formula developed by DSHA **CoC HUD are vouchers Connections was awarded – one of the criteria on the application was the organization would use the vouchers for clients in the Target Population as described in the Settlement Agreement

To better understand the variety of housing options below is a list of each program and its function:

State Rental Assistance Program (SRAP): The State Rental Assistance Program (SRAP) was created in partnership between the Delaware State Housing Authority (DSHA), the Department of Health and Social Services (DHSS) and the Department of Services for Children, Youth and their Families (the Kids Department) to provide State funding for housing vouchers for the clients within their particular programs.

This program was especially fortuitous because during the time the state-funded housing voucher program was being created, the state also was negotiating with the U.S. Department of Justice on the Settlement Agreement. SRAP was the logical way to meet a majority of the housing targets particularly "living independently in an integrated setting in the community." SRAP has funded the majority of the Settlement Agreement Target housing units (401) and an additional 74 units through other financial resources for a total of 475 units.

SRAP is similar to the federally funded Section 8 Program. A client is issued a housing voucher, the client searches for housing, negotiates with the landlord on the rent, and DSHA conducts a housing inspection to ensure the unit is in good condition. Assuming the unit passes inspection, the client signs a lease with the landlord, the Housing Authority pays the rental subsidy on a monthly basis, while the client pays 28 percent of his/her income toward the rent to make the total rental payment as stated on the lease. The SRAP voucher gives the client an opportunity to search statewide for housing and once the lease is signed, the client can move in and remain in that unit as long as s/he wishes and the landlord is willing to rent the unit.

Of the 475 funded vouchers, 353 have been leased, and 122 have been issued to clients, who are in various stages of finding and leasing housing.

Section 811 Project Based Rental Assistance: The Section 811 Project Based Rental Assistance Program is another partnership between the Delaware State Housing Authority (DSHA) and the Department of Health and Social Services (DHSS). In 2012, the U.S. Department of Housing and Urban Development issued a Notice of Funding Availability (NOFA) for a rental subsidy program. The primary requirement was that the State Housing Authority and the state department responsible for Medicaid-funded services partner to provide housing to state clients whom they serve. Also, states that have active settlement agreements with the U.S. Department of Justice were encouraged to apply. The NOFA required that the housing units be integrated in the community and not more than 25 percent of apartments in each complex would serve clients from the local DHSS.

DSHA submitted the proposal on behalf of the state and in mid-2012 the state received notice that the proposal was funded and that Delaware would receive funding for five years for approximately 140 units, with a possibility of funding renewal for up to 20 years.

The state spent the following two years in negotiations with HUD. The state is about to launch the program, which will provide additional housing units to DSAMH as well as other clients served by DHSS divisions.

Supervised Apartment Program (SAP): The SAP was transformed with the implementation of the Settlement Agreement. As has been stated, prior to the Settlement Agreement the service providers were given funds to manage their own apartments and provide on-site clinical services. After the signing of the Settlement Agreement, DSAMH

revised the SAP to have an outside property management company manage the units, a separate service provider to provide on-site supervision and the newly created ACT Teams to provide all the clinical services to the clients. Thus, the apartments were available to all the clients regardless of service provider.

Clients who participate in the SAP need additional supervision and prompting by both the ACT Team and the on-site service provider (that provides the 24/7 supervision). The SAP is for clients who are not yet ready to live independently and would benefit from having an on-site office to visit and where they can participate in fellowship as well as 24/7 "eyes-on" supervision.

In many cases a client who has been hospitalized and who does not have housing may be discharged to a SAP unit where the client can stabilize and the service provider (ACT Team) can understand the client's needs and assist in developing a person-centered recovery plan. Housing is always a part of the plan and knowing one's goals can define the type of housing the client will eventually occupy.

Clients who live in SAP can live there short-term or long-term depending on the needs and goals of the client. Typically, when a client is ready to move s/he will go to more independent living provided by an SRAP voucher or through an 811 rental assistance unit.

Resource Beds: A Resource Bed is a housing option that is used when a client is new to DSAMH services, has been hospitalized, and needs housing, but neither the service provider (ACT Team) nor the client know which housing option is the best. The client will be released from the hospital to a Resource Bed so both the service provider and the client have a chance to get to know each other and determine the client's wants and needs.

Transitional Housing: Transitional Housing is used when a client has been discharged from the hospital and has been issued an SRAP voucher, but has not yet found a place to live and needs a transitional unit while s/he continues looking for an apartment. Typically, the client can stay in a transitional unit for up to 90 days, which usually is enough time to find and lease a unit.

Crisis Apartments: The Crisis Apartments were required by the Settlement Agreement. "Crisis apartments are apartments where individuals experiencing a psychiatric crisis can stay for up to seven days to receive support and stabilization services in the community before returning home. The apartments serve as an alternative to hospitalization, and the clinical and peer staff assist individuals in de-escalating crisis without leaving the community." (Settlement Agreement Substantive Provisions C. Crisis Services e. Crisis Apartments page 5 and 6.)

The Crisis Apartments have served as an alternative to hospitalization as well as a housing option for persons who are being discharged from the hospital and do not have housing. The average length of stay for FY14 in New Castle County was 14 days and for Kent and Sussex County it was 7.4 days.

The Settlement Agreement required the State to host two beds in New Castle County and two in the southern two counties. The State has exceeded its goal and has four beds in NCC and four serving Kent and Sussex counties.

CRISP Housing: The CRISP program was created for clients who had been in the Delaware Psychiatric Center (DPC) for a number of years and who were to be discharged as a result of the Settlement Agreement. It is also for the clients who require more clinical services and in some cases cannot live independently. CRISP includes both clinical services and housing services as one capitated rate for the service provider.

Of the 90 CRISP clients living in the community, 57 are living in their own apartment in an integrated setting. The rest are either living in a two-bedroom unit, living with their parents or sharing a house with three or four people and staff.

SECTION III - ACCOMPLISHMENTS

The Settlement Agreement specified five target areas (see Appendix I for specific targets), which decentralized mental health services from institutions and clinics to the community. The targets ensured deeper community-based services, and integrated living and working supports (housing and employment were important targets for client integration) into mental health services.

By-products of the changing mental health service delivery system have been:

- The expansion of the peer programs, both as part of the state employment system and embedded in the service providers;
- The revision of the commitment laws, and
- The partnership between the Division of Medicaid and Medical Assistance (DMMA) and DSAMH researching, developing and submitting a State Plan Amendment and a Section 1115 Waiver amendment to CMS (Centers for Medicare & Medicaid Services) to enhance Medicaid-financed services for clients with Serious and Persistent Mental Illness (SPMI).

Peer Programs

***Definition of a Peer**:* A peer is a person who is the equal of another in abilities, qualifications, age background or status; a person who is of equal standing with another (Merriam Webster).
Peer Support is not like clinical support nor is it just about being friends. Peer Support helps people to understand each other because they've been there, share similar experiences and can model for each other a willingness to grow - (Gayle Bluebird – Director of Peer Services, Division of Substance Abuse and Mental Health, DHSS).

Overview of the Peer Movement Nationally

The History of the Consumer Survivor Movement – SAMHSA (Substance Abuse and Mental Health Services Administration) – Center for Mental Health Services webinar December 17, 2009 (Sally Zinman, Su Budd, Gayle Bluebird).

Below is an excerpt of the presentation:

The History of the Consumer Survivor Movement provides an overview of the patients/consumers who survived the trauma of long-term institutionalization and were suddenly released from the hospitals into the community without proper community supports in the '60s and '70s. They had each other, which then was consumers helping consumers, and today is called peers helping peers.

The groups that sprang up on each coast developed principles around:

- forced treatment;
- inhumane treatment (medications, lobotomy);
- seclusion, restraint and electroconvulsive therapy (ECT);
- anti-medical model, usually described as anti-psychiatry;
- emerging concept of consumer/survivor-run alternatives to mental health systems, and involvement in every aspect of the mental health system.

In 1985, the First National Conference of Alternatives was held, a conference held by and for persons with a mental illness, and has been held annually since then. From year to year it has been hosted by some of the Technical Assistance Centers including The National Mental Health Clearinghouse, which was founded by Joseph Rogers in 1986.

During the '90s and 2000s the movement has been informed by:

- self-determination and choice;
- rights protections, including the issue of involuntary commitment;
- reduction of stigma and discrimination;
- holistic services
- the concept of recovery as an outcome of treatment and the presumption of its possibility.

Overall, the consumer/survivor movement has played an important advocacy and public policy role for persons who have a mental illness.

PEER MOVEMENT IN DELAWARE

Prior to the Settlement Agreement, the Peer Program in Delaware was in its early stages. There were three Drop-in Centers, one in each county, which provided daytime activity for clients with SPMI. The Drop-in Centers provided some recovery-oriented activities, but also was a place for clients (consumers) to congregate for socialization and arts and crafts. There were few opportunities to assist the client with resume writing and employment searches. Some of the service providers offered peer-led training such as Well Recovery Action Plans (WRAP) and recovery groups such as AA, NA, and Double Trouble.

Additionally, some of the service providers employed peers, but they often were in traditional jobs and did not disclose their mental illness.

In Delaware, the Office of Consumer Affairs began in 2005 to develop peer specialist jobs and programs. DSAMH employed a peer who was and still is the Director of the Office of Consumer Affairs. This position has two responsibilities. One is to provide advocacy for individual consumers and the second is to provide system advocacy. The incumbent has routinely been on statewide committees and councils that are involved with consumer/peer issues. The office has been invited to many national conferences and task forces that assist states to aggressively pursue peer specialist programs, formal consumer input into policy and program development, and focus on the advancement of consumers' civil rights. When former Division Director Kevin Huckshorn arrived in 2009, she began the development of a peer program and peer specialist training was accelerated.

Currently we have the following peer programs:

- three peer drop-in centers;
- peer run shelter;
- peer art program, Creative Vision Factory;
- inpatient peers;
- mental health court peers;
- trauma peers, and
- provider-hired peers on recovery teams.

Recently, monthly meeting of consumers were moved to the community and an executive director was hired to develop the program statewide. It is important to note that while our peer programs are important and vital, we also advocate for people with a mental illness to be hired in all positions of DSAMH and our providers.

In Delaware before the Settlement Agreement, advocacy organizations consisted of the Mental Health Association of Delaware (incorporated in Delaware in 1932) and the National Alliance on Mental Illness of Delaware (incorporated in Delaware in 1983); the two major client (consumer) or family organizations responsible for raising critical service delivery issues with the Division of Substance Abuse and Mental Health; as well as the other senior-level state officials and elected officials. We also had a consumer coalition from 1995-2001 and again from 2009-2013.

The Settlement Agreement emphasized the need for stronger peer programs. It is one of the five target areas, and as such, has been an annual deliverable for the number of interactions that peers made with clients and families over the year.

Settlement Agreement Section II Substantive Provisions Para G. Family and Peer Supports #2 Peer Supports:
"Peer supports are services delivered by trained individuals who have personal experience with mental illness and recovery to help people develop skills in managing and coping with symptoms of illness, self-advocacy, identifying and using natural supports."

Thus, the Peer Movement in Delaware has become not just a target to meet on an annual basis, but a movement. It also meets the goals of Governor Markell in his blueprint for advancing employment opportunities for individuals with disabilities.

Employing Persons with Disabilities

During his yearlong term as Chair of the National Governors Association (NGA) from 2012 to 2013, Delaware Governor Jack Markell championed as his initiative with his fellow governors the advancement of employment opportunities for individuals with disabilities. After months spent researching the issue across the country with individuals with disabilities, employers, advocates, educators and government officials, Governor Markell released a blueprint to his fellow governors entitled, "A Better Bottom Line: Employing People with Disabilities."

The statement below by Governor Markell is from the blueprint. At the launch of the initiative in July 2012, the goal was to advance employment opportunities for individuals with significant disabilities by:

- Educating private-sector and public-sector employers about accommodating people with disabilities in the workplace and the benefits of doing so.
- Supporting state governments in joining with business partners to develop blueprints to promote the hiring and retention of individuals with disabilities in integrated employment in both the public and private sectors.
- Establishing public-private partnerships to build out those blueprints and increase employment of individuals with disabilities.

As an example of the Governor's commitment to the initiative, the State of Delaware website posted this announcement on October 7, 2014:

<u>State of Delaware Announces Class for State Employees on Employing People with Disabilities:</u>

All State of Delaware employees will be able to access a new online class, "Focus on Ability." This class will provide information about hiring and retaining employees with disabilities, including responding to and requesting accommodations, understanding invisible disabilities, and interacting comfortably and respectfully with people who have disabilities.

One of the leaders in employment has been the Peer Movement, which employs peers throughout the mental health system.

Examples are:

- DSAMH Office of Consumer Affairs is staffed by peers
- State employees and employees of the Mental Health Association in Delaware who work in the Delaware Psychiatric Center are peers
- Service providers are required to hire peers as part of the clinical service delivery to clients of DSAMH, which includes trauma-informed services
- The new PROMISE program will fund peer services
- Peers are in the Mental Health Court in New Castle County
- Delaware Consumer Recovery Coalition was a peer-run advocacy organization for peers
- Five peer-led nonprofit organizations (provide a number of services including shelter, drop-in programs, employment programs, recovery training, art center) hire peers for service delivery to peers (peers serving peers), and
- Projects for Assistance in Transition from Homelessness (PATH) is staffed by peers who work with homeless populations. The positions are funded through DSAMH from a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Overall, more than 100 individuals who have a mental health disability are employed throughout the state to deliver services through the mental health system, either working for a nonprofit or for the state.

State Peer-Staffed Programs

DPC Inpatient Peer Support and Community Services

Peer Support (PS) is a recovery-oriented model that has garnered significant attention within the mental health community. PS is defined by the fact that people who have similar experiences can better relate and can consequently offer more authentic empathy and focused advocacy. Given that Peer Support has only recently gained traction in the mental health community, evaluative performance measures have yet to be standardized and widely implemented. In an effort to accurately assess performance, the Performance Improvement Department at Delaware Psychiatric Center has developed qualitative and quantitative measures to assess the efficiency and effectiveness of the Peer Support Program in a standardized manner.

Performance Improvement System

This is a first in peer-driven performance management in the state. It is considered a role model and was presented at the annual meeting of the American Public Health Association during fall 2014.

Peer Support's Performance Measures: The proposed performance indicators are:

- 100 percent contact with admissions to DPC within 72 hours.
- Build relationships between peers and clients.
- Increase awareness of services available to clients.
- Achieve at least 80 percent client satisfaction.
- The tools by which performance will be measured are:
    - Hope Totes
    - Program Satisfaction Survey
    - Peer Support Exit Survey
    - Daily Peer Tickets, and
    - 360 Evaluation

(See Appendix III for statistics on the efficiency and effectiveness of the peer support program at DPC)

Peer Certification

The Peer Certification Program is in its second year. It was also developed by the DPC Inpatient Peer Support Team. The overarching goal is that all peers who are employed, be it for a nonprofit or for the State, will be trained and will receive a certification from the State Certification Board. As in every profession, the credentialing is a critical element and as such DSAMH has worked diligently to develop a curriculum that provides an emphasis on creativity as well as the fundamentals of peer services.

For example, the most recent peer certification curriculum included the following:

- History of the Consumer Movement
- History of the Peer Movement in Delaware
- Recovery
- Peer Support
- Boundaries, Ethics and Self-Disclosure
- How to Tell Your Story
- Community Services and Peers in Community
- Stigma
- USDOJ, ADA, Olmstead and the Settlement Agreement

Trauma Peers

Kevin Huckshorn, the former director of Division of Substance Abuse and Mental Health, was committed to achieving a culture of trauma-informed care for Delawareans with behavioral health conditions. She developed a grant application and DSAMH was awarded a grant from the Substance Abuse and Mental Health Services Administration to further this aim. A key aspect of the proposal was to employ a cadre of peer support specialists with trauma histories to implement activity required by the grant.

The trauma peers were the first employed by DSAMH to work with staff of behavioral health organizations in Delaware. Starting with five, the group eventually grew to 12 peers working in seven agencies (mental health, addiction and co-occurring disorder providers). Their assignments include collecting and submitting data required by SAMHSA and the trauma screening instrument; greeting new clients offering peer support; providing 1:1 peer support as requested; assisting with physical plant improvements such as furniture arrangement, wall colors, decoration; and coaching in the use of trauma-related reading materials. Several are facilitating peer-run support groups.

The Trauma Peer Project Manager is responsible for a variety of functions related to supervising and supporting the trauma peers, as well as offering a range of training designed to increase and broaden their skill sets. These include the above-mentioned peer-run support groups, arts and expression, body work, mindfulness meditation, and facilitating their completing both Delaware's peer support specialist certification and Wellness Recovery Action Plan (WRAP) training.

An important aspect of their growth and development as peer support specialists is the ability for several peers to present their trauma experience in public settings, for which the Trauma Peer Project Manager offered coaching and opportunities to practice, gradually expanding the audience from other peers to professional co-workers to audiences large and small.

After a five-year funding cycle, the Trauma Peer grant will expire this fall. The Trauma Peers who were interested in remaining in the state system were transferred to other Peer programs throughout the state ensuring that trauma services are imbedded in the Peer system in the state.

Mental Health Court Peers

The Mental Health Court Peer Specialist Mentor Program (MHCPS) began in New Castle County in October 2013 as a pilot program. The MHCPS works to support peer defendants in developing their continued recovery and treatment plan after being released from prison for a felony conviction.

The focus of the MHCPS is to be with the peer defendant during court hearings as well as provide referral services for such things as housing, employment and other services necessary when a person is released from prison. The MHCPS works closely with the Mental Health Court Team in the New Castle Superior Court to help peer defendants achieve their goals and to transition back to the normality of living in the community as soon as possible.

The MHC peer team currently consists of four peer mentors and a director, who is a certified peer specialist. All were selected because of their past histories or their experience in the criminal justice system. The peer also must have excellent communication skills and been trained to be a certified peer specialist.

The peer mentors are available to the client for individual peer support, counseling, trouble-shooting, and emergency situations, as well as other needs.

Some of the services that the MHC provides may include:

- Transportation to TASC, probation and doctor's appointments;
- Employment leads;
- Housing referrals; and
- Food Bank locations.

The peer defendant is assigned a peer when s/he is still in prison or on probation while in the community. Typically, the director of the program is given a list of names of former inmates or inmates who are eligible for the program and she assigns a peer according to the previous experiences of the peer and the peer defendant.

There are two ways a peer defendant may access the program. The first is through the Mental Health Court (meaning they have already committed a crime and are in jail or prison waiting to go to MHC) or through the diversion program where the peer defendant has not yet gone to jail or prison and if s/he participates in the six-month program the charges will be dropped.

If a person comes through the MHC and is willing to participate in the Mentor program s/he may be in the program for several years and regardless of the person's success in the program the charges are not dropped. Peer support services include peer counseling, mentoring, support and advocacy according to the needs, interests and perspectives of peer defendants receiving services in Mental Health Court. The ultimate goal of a peer specialist is to further a peer defendant's ability to move forward and to transition into the community as soon as possible.

Office of Consumer Affairs

As highlighted above the Office of Consumer Affairs, which was established in 1993, has consistently demonstrated the need for consumer and family support and programming. The director's commitment to recovery has been one of the few voices that had held the Peer Movement together before the Settlement Agreement.

The latest initiative from the Office of Consumer Affairs, The Loneliness Project, is a collaboration between DSAMH and University of Pennsylvania (UPenn). The primary aim is to identify loneliness and its manifestations in persons with mental health and substance abuse disorders. Key outcome domains of the Loneliness Survey are: 1) exercise; 2) sleep quality; 3) relationships; and 4) community integration. The Division presented a conference on loneliness in April 2015.

The survey sample will come from three sources:

- Consumers of outpatient mental health and substance abuse services**;**
- Community Re-Integration Support Program (CRISP) Consumers; and
- Consumer attendees of the 2014 Peer Empowerment Conference**.**

Individuals in these three groups will be asked to complete the loneliness survey independently. Peer specialists and/or representatives of DSAMH's Consumer Affairs Office will supervise survey distribution and completion at each site and will be available to answer questions or to help with completion if needed (i.e., reading the questions to a consumer).

Upon completion of the surveys, the data will be sorted and evaluated for follow-up activities. Specifically, it is the intention of the Office of Consumer Affairs to review "The Loneliness Workbook" by Mary Ellen Copeland to determine if it would be of use to the consumers (clients).

Overall, peers have made a considerable impact on the state mental health system. They are embedded in every aspect of service delivery.

"On the Road Again"

One day in February, I was meeting with a client when she stated that she had a son who was incarcerated. I knew that reuniting them would be integral in her physical & mental well-being and recovery. So, at treatment team meeting the following day I decided to apprise the team of my proposed plan. I initially summoned the assistance of a former co-worker working for a service provider for contact information, to no avail. So I then proceeded to request assistance from a staff person at DPC. She was able to contact an individual who directed me on my path, to get "on the road again."

I contacted the Sussex Correctional Institution in Georgetown, to inquire about what was needed to "make it happen" reuniting my client with her son. They asked for pertinent information about all the potential visitors. Once I was able to collect the information the visit was officially scheduled for February 25, 2014.

I reserved the car and we began our journey "on the road again"…… The ride was very relaxing and I was so excited for my client to finally see her only child. After some difficulty negotiating the parking requirements at the prison we were then confronted with requirements about what can and cannot be taken into the prison. My client had $1.75 cents in another one of her many pockets. After confiscating the buck and change, I decided that I was not going to walk back to the car that was parked all the way across the lot! I went outside as the guard instructed me, to patiently await a passerby……BINGO! There was an older lady coming out; I approached her nicely and gave her the loot.

So, moving forward, we were escorted into the visiting area to be searched and thankfully we were all clean….no contraband! Now, we just have to wait for her son to be escorted to the visitor's hall. When he arrived, he immediately embraced his mother, my client, and the flood gates of our tear ducts opened. I was crying, she was crying and he was crying.

After the first visit we were afforded the opportunity for a second, because the son had no other visits that week. They talked about when she was younger, and how much more time he has left before release. I chimed in on the conversation, with all the information that was pertinent to his mother's current situation. He asked me if I would watch after his mom and to keep him apprised of how she was. I assured him that I would, because I was very much invested in his mom….Speaking of keeping him informed, I will be writing him this week since it's been almost a month since we went "on the road"!

"A Story of Empowerment in Spiritual and Emotional Wellness"

*I supported a client as she became empowered to pursue her long standing recovery goal of seeing a Christian counselor. The client and I researched local options for Christian counseling, and she chose the one she felt would be the best fit for her. She called to make the appointment and completed the intake paperwork on her own. At one point, the receptionist at the counseling office asked to speak to me, as she was skeptical that someone on an inpatient unit at DPC would be "allowed" to make this decision for herself. "Are you **sure** this woman will be able to get here?" I gladly assured her that the client would be able to make the appointment. On the way to the appointment, we stopped and had lunch at Olive Garden. The client really enjoyed herself. Upon our return, she told everyone that she came across how much fun she had, and how she really liked having lunch at Olive Garden.*

"Supporting Others in Finding Meaningful Employment"

The month of June was truly an experience for me. I was placed on the K2 unit to begin working with clients once again. After my first day I was already in the swing of things. I attend treatment team twice a week. Because of my time in the Drop Zone I have developed a relationship with clients from all units, not just K2, like the young man on S3 who prefers me to braid his hair, or the client on K3 who trusts me because we know each other from elementary school. I am currently working with SRAP clients to find them housing before the voucher expires. I am also co-facilitating a new program on the Recovery Academy called "Employment Readiness." This program will help our clients with getting ready for the working world! We will be utilizing all skills from what to wear on an interview, to getting and keeping a job. I was excited to see the turnout for the first program—this is an area that really interests our clients.

PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment)

The PROMISE Program is a joint venture between the Division of Medicaid and Medical Assistance (DMMA) and DSAMH. It is an outcome of the Affordable Care Act, revisions to the FY14 State Plan Amendment (SPA), and the Settlement Agreement. PROMISE's goal is to provide community supports to facilitate enhanced engagement within the community for persons with serious and persistent mental illness.

The partnership between the two divisions led to the development of a comprehensive Medicaid waiver that would allow the state to leverage federal funding (Medicaid dollars) with state funding. The enhanced Medicaid benefit package is being coordinated by DSAMH through the fee-for-service program in compliance with home and community-based standards and assurances that the services meet the standards of the signed Olmstead agreement.

The goals are to improve clinical and recovery outcomes for individuals with behavioral health needs and reduce the growth in costs through a reduction in unnecessary institutional care through care coordination, including initiatives to increase network capacity to deliver community-based, recovery-oriented services and supports.

Specifically, the Medicaid funding will provide:

- federal reimbursement for crisis intervention, substance use disorder (SUD) treatment and treatment by other licensed practitioners.
- home and community-based services for individuals in the Settlement Agreement target population.

PROMISE Program Goals:

- Provide behavioral health (BH) supports in a community-based setting.
- Assist individuals with BH needs to work in a competitive work environment.
- Provide individually tailored services for individuals with BH needs.
- Leverage limited State dollars to better meet the needs of the target population
- Ensure that individuals with BH needs live in the community with the appropriate services and supports.

Expected Outcomes of PROMISE:

PROMISE will modernize and improve the delivery of mental health and substance use services. Recovery-oriented services will be delivered according to a written person-centered plan of care, called a Recovery Plan, developed through a process led by the individual, including people s/he has chosen to participate.

The person-centered planning process must identify the individual's physical and mental health support needs, strengths, preferences and desired outcomes. For individuals receiving other Medicaid services, PROMISE will provide a coordinated approach to services.

Eligible individuals will be:

- Over the age of 18 years.
- Diagnosed with a mental illness, co-occurring and substance use disorders.
- Identified as having either moderate or severe functioning on the Delaware specific American Society for Addiction Medicine (ASAM) assessment tool that evaluates both mental health and SUD conditions. The individual may also be found to continue to need at least one service or support in order to live/work independently.

PROMISE-Funded Services:

- Care management
- Individual employment services
- Short-term small group supportive employment
- Financial coaching
- Benefit counseling
- Peer support
- Non-medical transport
- Community-based residential supports excluding assisted living
- Nursing
- Community-based psychiatric supports and treatment
- Psychosocial rehabilitation
- Respite
- Independent activities of daily living/chore
- Personal care
- Community transition services

PROMISE Person-Centered Planning:
Delaware is developing comprehensive quality strategies that are integrated with existing State quality strategies to ensure that services delivered produce positive results.

There is no one-size-fits-all service plan, and the Individuals in PROMISE will have the key voice, with support as needed, in directing, planning, and implementing service delivery, and will indicate who they want to be involved.

The person-centered planning process itself will:

- Be timely and occur at times and locations of convenience to the individual.
- Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
- Offer choices to the individual regarding the services and supports they receive and from whom.
- Success will be measured against individual's goals for recovery.

The PROMISE program will enhance opportunity for clients to receive the best possible services, from their choice of the service providers. The fee-for-service component allows for more service providers to offer services to the consumers. PROMISE began in January 2015 with approval from the Centers for Medicare and Medicaid (CMS) and when DHSS' new Managed Care Organizations contracts started.

It is a credit to both DSAMH and DMMA in partnering to submit a waiver to the CMS to provide funding for comprehensive services to the behavioral health population of Delaware. Reform in the public behavioral health system is a commitment across the department and cabinet and this effort is another demonstration of leveraging offerings to enhance the lives of individuals with SPMI.

Effect of the Settlement Agreement on State Services

The Settlement Agreement has influenced the partnerships within the state systems as well as provided integration of services between divisions and outside funders. For example, both DMMA and DSAMH provided services to citizens of the State of Delaware who suffered from mental health disabilities. Before the Settlement Agreement, there were few joint services. Typically, clients funded by Medicaid who required deep end mental health services were referred to DSAMH, however, the client would continue to receive physical health services from Medicaid, but all mental health services were funded by DSAMH. This was an annual process that had to follow Medicaid rules and the requirements of the state agreements with CMS.

PROMISE changes the way clients receive mental health services and created a bridge between DMMA, the Managed Care organizations and DSAMH. The partnership has been extraordinary and the benefit to the clients is unsurpassed from any service that has been provided up to this point.

House Bill 311, 346 and HJR 17

Background on House Bill 311 and HJR 17:
Prior to July 1, 2013, any medical doctor in Delaware could petition for an individual to be held on a 24-Hour Emergency Detention to determine the need for psychiatric hospitalization. There were a high number of clients with suspected mental health conditions in Emergency Rooms, non-mental health professionals requesting psychiatric detentions, and as a result, a high number of unnecessary psychiatric hospitalizations. The Settlement Agreement had an effect on the process by which persons were involuntarily detained. The DSAMH staff consulted a review of the statistics of persons detained and the reasons for the detention, and determined that it was an excessive use of the commitment laws. Information was shared with the Cabinet Secretary of DHSS and the Legislature, with the result being the development of House Bill 311 and House Bill 346

The Legislature recognized the need to change the 24-hour detention process and created Credentialed Mental Health Screeners, permitting only individuals who are certified screeners to initiate a 24-hour detention for psychiatric assessment. Law enforcement personnel may be involved if public safety is a concern, but only a Credentialed Mental Health Screener can decide a person must be held involuntarily for a 24-hour evaluation. In addition to certified mental health screeners (with professional and educational backgrounds meeting the certification requirements as established by DSAMH and who are trained and certified by the state), the medical community depending on their specialty may be waived in as a screener or have a minimal required training prior to certification as a screener.

As stated in the HJR 17 Civil Mental Health Law Study Group Report (page 3), "During the discussions of HB 311, it became apparent that Delaware's civil mental health laws (Title 16, Chapters 50 and 51 of the Delaware Code) had not been comprehensively reviewed in decades and since that time there have been substantial advancements in the treatment and care of persons with mental conditions."

Thus, HJR 17 was drafted by the Legislature to allow for a Civil Mental Health Law Study Group to be formed who was tasked with investigating the civil mental health laws.

In April 2014, the Final Report of the HJR 17 Civil Mental Health Law Study Group was published by the HJR 17 Study Group Chair Rita Landgraf, Cabinet Secretary of the Department of Health and Social Services. The report outlines the activities of the Study Group and its recommendations. The State Legislature-appointed Study Group members and other Study Group members allowed for ad hoc stakeholders to attend each committee meeting, and to participate in the necessary research, discussion and recommendations.

The Study Group is significant because it represents the State's commitment to reviewing and, if necessary, revising the civil mental health laws.

The Study Group Report can be found as Appendix II to this Annual Report. The report describes in full, the yearlong process of researching, discussing, and recommending changes in the civil mental health laws.

Mental Health Screeners

As explained in the section "**House Bill 311 and HJR 17**," prior to July 1, 2013, anyone in Delaware could petition for an individual to be held on a 24-hour emergency detention to determine the need for psychiatric hospitalization. There were a high number of clients with suspected mental health conditions in emergency rooms, non-mental health professionals requesting psychiatric detentions, and as result, a high number of unnecessary psychiatric hospitalizations.

Delaware-licensed psychiatrists are automatically Credentialed Mental Health Screeners. Psychiatrists and Board-Certified Emergency Room physicians are required to review a packet of training materials related to the process. Other professionals may become Credentialed Mental Health Screeners pursuant to regulations promulgated by DSAMH.

Delaware-licensed physicians (who are not Board-Certified in Psychiatry or Emergency Medicine) are required to complete a four-hour block of instruction, while licensed mental health professionals and unlicensed mental health professionals who work under the direct supervision of a psychiatrist must complete a week-long training. Pursuant to the regulations, mental health professionals with a bachelor's degree or above and Registered Nurses must complete a 40-hour training course and pass an examination to be certified as a screener.

Screeners are expected to have a more thorough understanding of the concept of dangerousness to self or others, and to be more knowledgeable about community-based care interventions that can prevent individuals from being hospitalized unnecessarily.

The State began the training for the Mental Health Screeners (MHS) in FY13 with its first class of 92 students. In FY14 the state trained an additional 52 students and in FY15 another 47 students for a total of 191 persons trained to be Mental Health Screeners.

In August 2014 the State held a refresher course of which 83 MHS attended.

House Bill 346 HJR 17 further noted that it is in the interest of the State that "people be able to access the most appropriate mental health treatment, in the most appropriate but least restrictive setting, at the most appropriate time." This bill is the result of recommendations made by the HJR 17 Study Group.

It is important to note at the outset that the changes in this bill appear more comprehensive than they actually are because one of the primary changes made by this Act is the combination of Chapter 50 with those portions of Chapter 51 dealing with civil commitment. Combining the chapters creates consistent definitions and a logical and structured process. The language and definitions of both chapters have been updated to reflect modern usage, current terms and promote consistency across the Delaware Code.

Substantive changes were made to modernize procedures and provide better civil rights protections to patients. Much attention was paid to making a consistent process, so that people enter civil mental treatment in a consistent manner with due process protections and that similar protections and treatment philosophies are applied across the different levels of treatment.

The voluntary admission process was revised to require a clearer showing of informed consent by the individual requesting to be voluntarily admitted. The proposal also reduces the timeframe to discharge a voluntary patient who requests discharge in writing from the current five working days to 72 hours.

The proposal broadly adds additional safeguards and removes the ability to provisionally admit someone based on property destruction; it removes the ability of psychiatrist to bypass emergency detention through the use of provisional admission; it adds in explicit language that an individual who is provisionally admitted shall not be considered "involuntarily committed" for any legal purpose; but it allows for 48-hour admission following a 24-hour emergency detention.

The following due process protection have been added after an involuntary inpatient commitment has been ordered: the order may not exceed three months; shall be based on the court's individualized assessment of the facts and circumstances; at the end of the three month period, an individual is entitled to a hearing with at least a 14-day notice if continued inpatient treatment is ordered, hearings are held every three months to review the case.

Other changes include appeal rules that better reflect Superior Court rules. Discharge requirements will explicitly extend to private psychiatric hospitals as well as DPC. This will not functionally change services already being provided by psychiatric hospitals because the majority of what is covered by provision is already required elsewhere in Delaware Law.

Due process protections were added for youth. Parallel to the adult system, the Study Group recommends that emergency detentions be done only by psychiatrists and "Juvenile Mental Health Screeners." However, because they are minors, consent for voluntary admissions to designated psychiatric treatment facilities or hospitals may only be given by a parent or legal guardian and such requests must be signed by a parent or legal guardian.

Once admitted, minors or their parents or legal guardians may make a written request to the psychiatrist to be discharged at any time. Discharge may be conditioned upon the consent of the parent or legal guardian. If the parent or legal guardian of a voluntary patient requests discharge against medical advice, the involuntary treatment procedures may be initiated.

At the recommendation of the HJR17 Study Group, consent for voluntary outpatient mental health treatment for minors under the age of 14 requires the consent of a parent, legal custodian, or legal guardian. However, for minors age 14 to 18, the minor or the parent / legal custodian / legal guardian may provide the consent. A minor, including those 14-18, cannot overrule consent provided by a parent/legal guardian / legal custodian. A parent/legal custodian / legal guardian may not abrogate the consent provided by a minor age 14 or older. Psychotropic medication requires the consent of the parent, legal guardian, or legal custodian.

A different time frame is proposed for minors than adults for emergency detentions. When minors are emergently detained, the evaluation and treatment shall occur within 24 hours unless the parent or legal guardian is unavailable during that initial 24-hour period. In such instances the time period may be extended to 72 hours. Finally, the proposed legislation establishes the ability for the Secretary of the Department of Services for Children, Youth and Their Families to designate a psychiatrist or Institutional Review Board to review the emergency detention decisions of Juvenile Mental Health Screeners on an individual case or aggregate basis.

STATUS OF THE SETTLEMENT AGREEMENT TARGETS FOR FY14

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

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

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

Below are the targets and the goals within the targets that relate to Year Three (FY14) of the Settlement Agreement. The Court Monitor has rated each target which is also documented below as they are outlines in the Settlement Agreement (for the full Court Monitor Report dated December 29, 2014 see the DSAMH website):

III. Implementation Timeline:

Crisis Services – Targets by Fiscal Year

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

- ***Crisis hotline:*** staffed by licensed clinical professionals 24 hours per day, seven days per week, with toll-free access throughout the state.

- ***Mobile crisis teams:*** who can work with trained law enforcement personnel to respond to people at their homes and in the community, available to respond within one hour, 24 hours per day, seven days per week.

- ***Crisis walk-in centers***: which can provide community-based counseling to individuals experiencing a mental health crisis 24 hours per day, seven days per week.

- ***Crisis stabilization services:*** or short-term acute inpatient care, intended to help stabilize clients and discharge them back to the community within 14 days.

- ***Crisis apartments:*** where individuals experiencing a psychiatric crisis can stay for up to seven days to receive stabilization and support services in the community prior to returning home.

Below are the targets for each of the crisis service components for each year of the Settlement Agreement and the progress made by the State for each are as follows:

Crisis Hotline – Targets by Fiscal Year

- By January 1, 2012 (FY12): The State will develop and make available a crisis hotline for use 24 hours per day, 7 days per week. ***Substantial Compliance***
- By July 1, 2012 (FY12): The State will provide crisis line services publicity and training materials in every hospital, police department, homeless shelter, and Department of Correction facility in the State. ***Substantial Compliance***
- There are no targets for FY13: The State continues to host a 24/7 crisis hotline and provide information about the Crisis Hotline as defined in the Target for FY12. ***Substantial Compliance***
- There are no Targets for FY14: The State continues to host a 24/7 crisis hotline and provide information about the Crisis Hotline as defined in the Target for FY12. ***Substantial Compliance***

Substantial Compliance

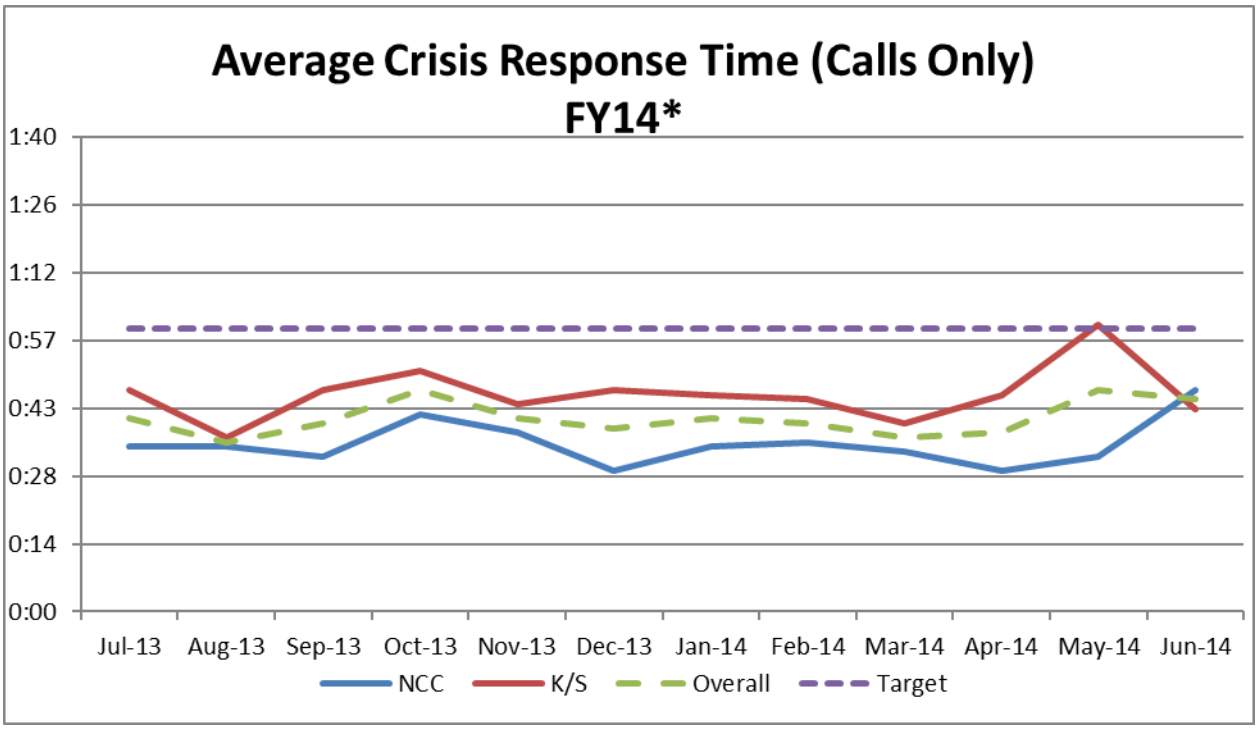
The State has met its targets and continues to maintain a 24/7 crisis hotline. It is also conducting training and providing information to the communities that would naturally use the Crisis Hotline Services. DSAMH maintains monthly data on the number of calls received by the Crisis Hotline.

Mobile Crisis Teams – Targets by Fiscal Year

- By July 1, 2012 (FY11): The State will make operational a sufficient number of mobile crisis teams such that a team responds to a person in crisis anywhere in the State within one hour. The State created a downstate Mobile Crisis Team based in Sussex County, but serves both Kent and Sussex counties. ***Substantial Compliance***
- By July 1, 2013 (FY13): The State will train all state and local law enforcement personnel about the availability and purpose of the mobile crisis teams and on the protocol for calling on the team. ***Substantial Compliance***
- There are no Targets for FY14: The State continues to maintain two Mobile Crisis Teams -- one in New Castle County and one serving Kent and Sussex counties. The average response time for both teams is within an hour from the time the crisis call is received.. ***Substantial Compliance***

Substantial Compliance

The State continues to be in Substantial Compliance for both the training of law enforcement personnel as well as responding to a face-to-face basis for crises that are not stabilized by a conversation on the phone. The Mobile Crisis teams have had success de-escalating many crises on the phone. For that crisis that requires a face-to-face visit, the Mobile Crisis teams consistently respond within an hour of the initial phone call. Below is a chart that represents the State FY14 response time by county.



Data compiled from monthly statistics from the Mobile Crisis Teams in NCC and downstate.

Crisis Walk-in Centers – Targets by Fiscal Year

- By September 1, 2012 (FY12) The State will make best efforts to make operational one crisis walk-in center in Ellendale to serve the southern region of the State no later than September 1, 2012. ***Substantial Compliance***
- By July 1, 2013 (FY12): The State will train all state and local law enforcement personnel about the availability and purpose of the crisis walk-in centers and on the protocol for referring and transferring individuals to walk-in centers. ***Substantial Compliance***
- There are no Targets for FY13: The State continues to provide walk-in-services for Kent and Sussex counties, as well as train the law enforcement personnel about the availability of the walk-in-services. ***Substantial Compliance***
- There are no Targets for FY14: The State continues to provide walk-in-services for Kent and Sussex counties, as well as train the law enforcement personnel about the availability of the walk-in-services. ***Substantial Compliance***

Substantial Compliance

The State has been collecting data from the RRC for the complete fiscal year (FY14) and is continuing to collect data for FY15. The data has been instrumental in informing "next steps" in developing a walk-in center in New Castle County similar to the one in Ellendale. The Crisis Walk-In Center in Ellendale has been a success in diverting clients from in-patient psychiatric hospital stays for up to 77.6 percent of the time. Of the total clients seen for FY14 at the RRC, 21.3 percent of the clients require additional in-patient care and were referred to a psychiatric hospital; 11.1 percent of the clients had substance abuse issues and were referred to residential treatment; and the remainder were diverted from additional in-patient treatment.

Because of the success of the RRC in Ellendale, DSAMH decided to replicate the program in New Castle County. An RFP was advertised and has been awarded to Recovery Innovations. Within FY15, a new RRC in New Castle County will be opened as the upstate crisis walk-in center.

Recommendations in Report 6 of the Court Monitor:

"Use of Crisis Walk-In-Centers to assess individuals who are under 24-hour psychiatric detentions is a very important, positive measure. It is recommended that the State develop monthly "dashboard" measures to track the impact of this initiative and, as may be indicated, to further refine or expand within the Crisis Walk-In-Centers."

Crisis Stabilization Services – Targets by Fiscal Year

- By July 1, 2012 (FY12): The State will ensure that an intensive services provider meets with every client receiving acute inpatient stabilization services within 24 hours of admission to facilitate his/her return to the community and that the transition planning is completed with standards set forth in the agreement (Section IV of the Agreement). ***Partial Compliance***
- By July 1, 2013 (FY13): The State will train all provider staff and law enforcement personnel to bring individuals in crisis to crisis walk-in centers for assessment rather than to local emergency rooms or private psychiatric hospitals. ***Substantial Compliance***
- By July 1, 2014 (FY14): The number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 30 percent from the State's baseline on the effective date of the Settlement Agreement. ***Partial Compliance***

Partial Compliance

The reduction of inpatient bed days is based on ensuring that there are enough community services to appropriately serve the SPMI population in the community, not in a hospital setting. There are many factors that affect the success of reducing inpatient bed days: coordination of care between the service provider and the client, availability of community services, use of Crisis Walk-In-Centers, coordination of Utilization Review by nurses who are employed by the funder (DSAMH or the Managed Care Organizations that managed the Medicaid clients) to name a few.

The State has reduced bed days by 22.6% instead of the 30% reduction as required by the Settlement Agreement.

See The Court Monitor Report dated December 29, 2014, for a further discussion on reduction of in-patient bed days and recommendations on how the State can more fully succeed in the goal of reduction of 50% by FY16.

Discharge Planning – Page 5 Settlement Agreement

- Section II. C.2.diii-iv of the Agreement require that "an individual is admitted for acute care, intensive support service providers will engage with the individual within 24 hours of admission in order to facilitate a quick return to the community with necessary supports."

Partial Compliance:

As in every system when there is an effort to modify or change a process it takes time because of the many moving parts. It is no different for the discharge planning process. There are many groups that have to revise the way they conduct business to meet the requirements of the Settlement Agreement. For example, the IMDs (Institutions for Mental Disease), the service providers, the doctors, the clients, DSAMH, MCOs (Managed Care Organizations), DPC and anyone who is involved in a hospitalization as well as a discharge.

Because of the volume of organizations that provide services to clients with serious and persistent mental illness there has been some difficulty in ensuring that all service providers meet with the hospital within 24 hours of admissions. Both DSAMH and DMMA are working with the service providers and the hospitals to coordinate care and discharge planning.

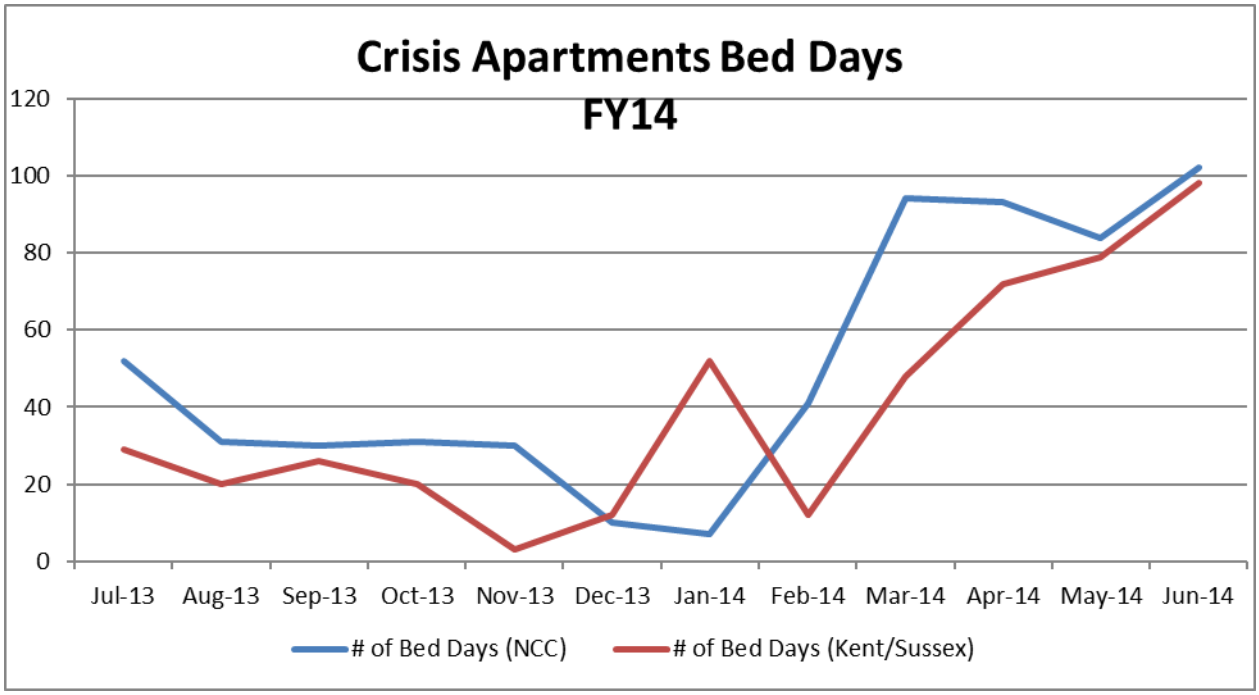
To read more about Discharge Planning see the Court Monitor Report dated December 29, 2014.

Crisis Apartments – Targets by Fiscal Year

- By July 1, 2012 (FY12): The State will make operational two crisis apartments. ***Substantial Compliance***
- By July 1, 2013 (FY13): The State will make operational a minimum of two additional crisis apartments, ensuring that the four apartments are spread throughout the State. ***Substantial Compliance***
- There are no Targets for FY14: The State expanded its crisis apartment beds from 2 beds in New Castle County and 2 beds for Kent and Sussex Counties to 4 beds for New Castle County and 4 beds for Kent and Sussex Counties. ***Substantial Compliance***

Substantial Compliance

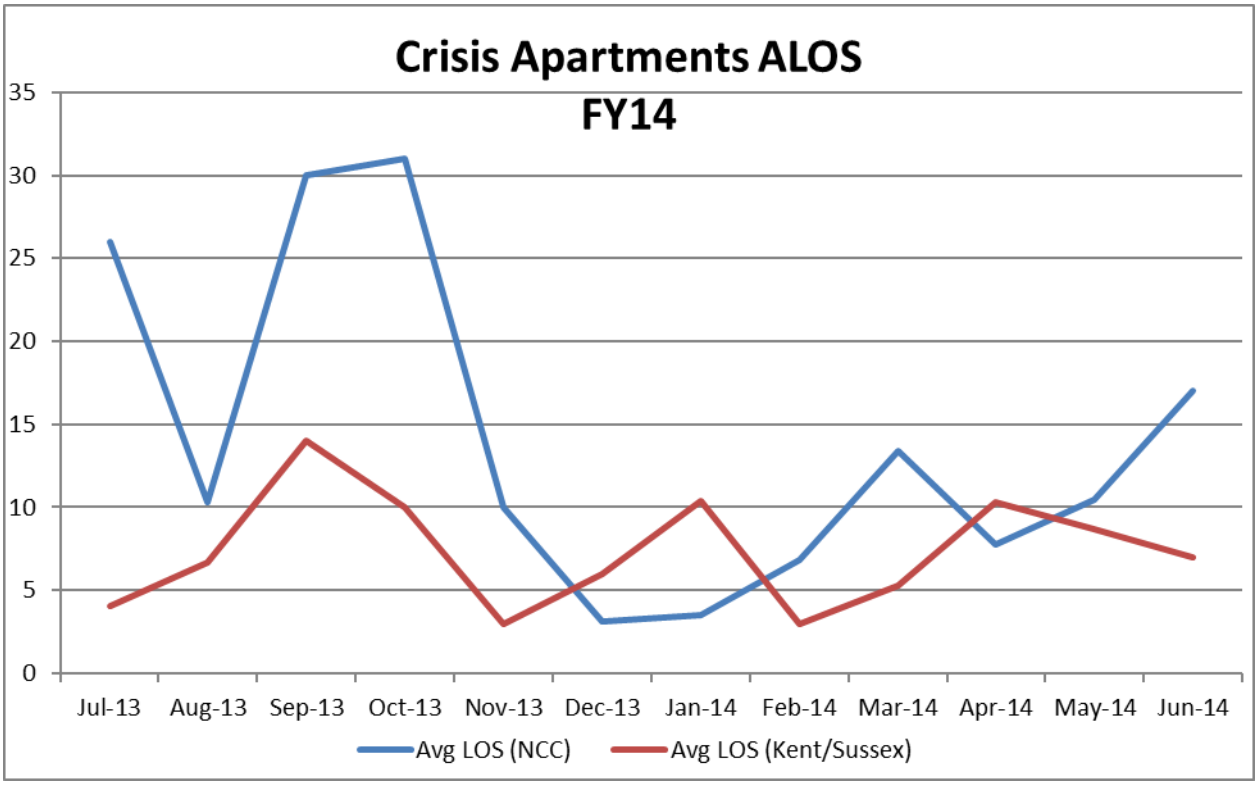
The State expanded the number of beds in January 2014. The increase in usage has to do with the outreach activities by Recovery Innovations (the service provider who manages the Crisis Beds). There has been an increase in demand for the beds.



Data based on monthly reports from Recovery Innovations for FY14

The crisis beds typically have a 3-5 day limit on the length of stay. Although, if the client who is occupying a bed is homeless the stay may be up to 10 or more days while the service provider searches for housing

alternatives. The key to a short stay is based on the efforts of the service providers to secure housing for the clients as soon as possible.



DSAMH Data obtained from RI FY14 monthly data - July 2014

Assertive Community Treatment – Targets by Fiscal Year

- By July 1, 2012 (FY13): The State will expand its 8 ACT teams and bring them into fidelity with the Dartmouth model. ***Substantial Compliance***
- By September 1, 2013 (FY14): The State will add an additional ACT team that is in fidelity with the Dartmouth model for a total of 9. ***Partial Compliance***
- By September 1, 2014 (FY15): The State will add an additional ACT team that is in fidelity with the Dartmouth model for a total of 10.

Substantial Compliance

The State exceeded the required total of 9 ACT teams by September 1, 2013 (FY14). It has also exceeded the required total of 10 for FY15. As of June 30, 2014 the State had a total of 11 ACT teams one of which was a ICM team that was converted to an ACT Team.

The State with the agreement of the Court Monitor converted the ACT Team from the Dartmouth Model to the TMACT model. In so doing the State had to retrain the service providers in the new fidelity model (TMACT). The Quality review process determined that the average score of the service providers under TMACT was 3.6 out of 5.

The Court Monitor, per his report dated December 29, 2014, determined that the State was in partial compliance. The suggestion was that the State work with the service providers around "engagement of

natural supports" with the clients, and encourage the service providers to improve their overall scores.

Intensive Care Management – Targets by Fiscal Year

- By July 1, 2012 (FY12): The State will develop and begin to utilize three ICM teams. ***Substantial Compliance***
- By January 1, 2013 (FY13): The State will develop and begin to utilize an additional ICM team for a total of four teams. ***Substantial Compliance***
- There are no targets for FY14: The State had five ICM teams in FY14, exceeding the target of one team. In FY14, the State consulted with the Court Monitor to convert four of the five ICM teams to ACT Teams.

Substantial Compliance

The State exceeded the Targets for the ICM teams in FY14. During the year of FY14 the State determined that ICM Teams were not providing the services needed by the clients and thus it was decided that a higher level of care would be provided to clients in Kent and New Castle counties. The four ICM teams (three in New Castle and one in Kent) would be converted to ACT Teams respectively in FY15. The ICM Team in Sussex County would remain an ICM Team.

Case Management- Targets by Fiscal Year

- By July 1, 2012 (Beginning of the Settlement Agreement): The State will train and begin to utilize 15 case managers. ***Substantial Compliance***
- By September 1, 2013 (FY14): The State will train and begin to utilize three additional case managers for a total of 18 case managers. ***Substantial Compliance***
- By September 1, 2014 (FY15): The State will train and begin to utilize three additional case managers for a total of 21 case managers. ***Substantial Compliance***

Substantial Compliance

The State has exceeded the Target for FY14. The Targeted Case Managers are part of the State system and are also on contract with a service provider organization. The State TCM provides a high level of care which includes access to transitional housing, which is used when a client is in need of housing and has not yet secured permanent housing.

The TCM services provided by a service provider organization, Recovery Innovations, offers short-term case management services until the individual is established with an ACT Team or ICM Team if the person lives in Sussex County. TCM, also known as Restart, provides case management services, which include connecting the client to housing and other services as defined in the Settlement Agreement.

Supported Housing – Targets by Fiscal Year

- By July 11, 2011 (beginning of Settlement Agreement): The State will provide housing vouchers or subsidies and bridge funding to 150 individuals. This housing shall be exempt from the scattered-site requirement. ***Substantial Compliance***

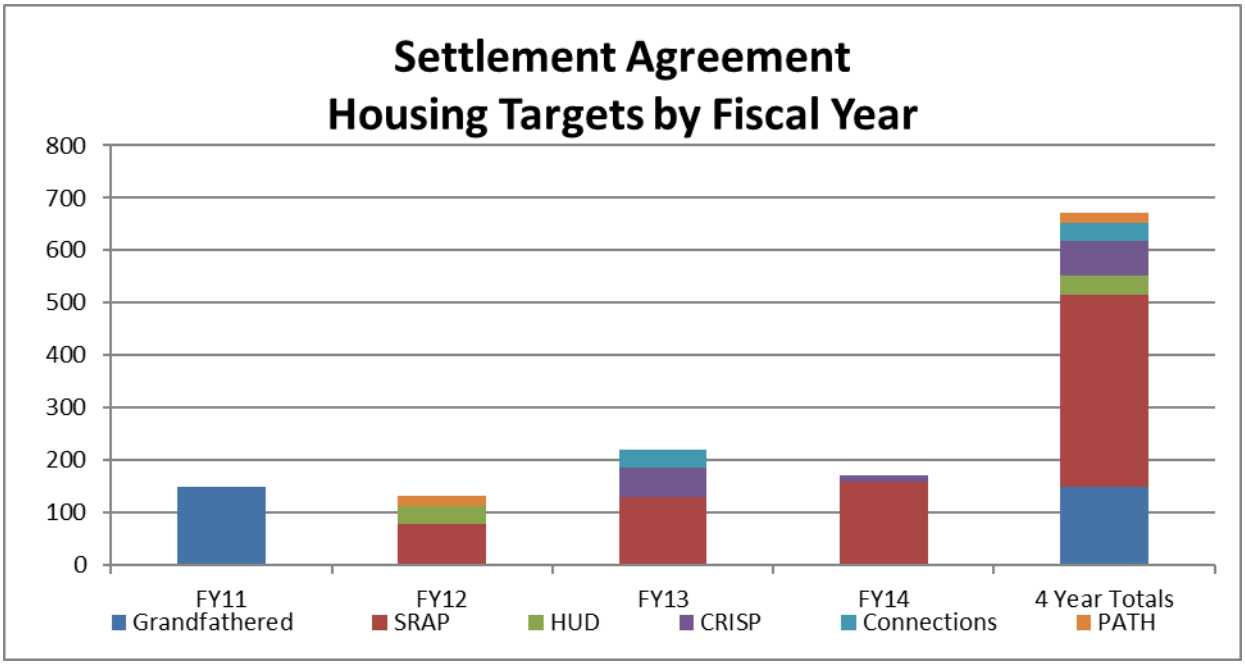
- By July 1, 2012 (FY12): The State will provide housing vouchers or subsidies and bridge funding to a total of 250 individuals. ***Substantial Compliance***
- By July 1, 2013 (FY13): The State will provide housing vouchers or subsidies and bridge funding to a total of 450 individuals. ***Substantial Compliance***
- By July 1, 2014 (FY14): The State will provide housing vouchers or subsidies and bridge funding to a total of 550 individuals. ***Substantial Compliance***

Substantial Compliance

The State has met its Target for FY14 of 100 integrated units.

Year Four (FY15), the year in which the State is currently, is the last year with a defined housing target – 100 units. Year Five (FY16 beginning July 1, 2015) is the last year of the Settlement Agreement and the target for housing, as stated in the Settlement Agreement, is to be determined based on the "needs of the Target Population who need housing." (Settlement Agreement Page 13 I. Supportive Housing #6)

The largest contributor to the integrated housing target is the State Rental Assistance Program (SRAP), a state-funded housing voucher program.



FY11: The Target was 150 units all of which were grandfathered in by the U.S.DOJ

FY12: The Target was 100 units which were identified through SRAP, HUD Section 8 Vouchers

FY13: The Target was 200 units which were identified by CRISP, SRAP and HUD Continuum of Care Section 8 Vouchers awarded to Connections

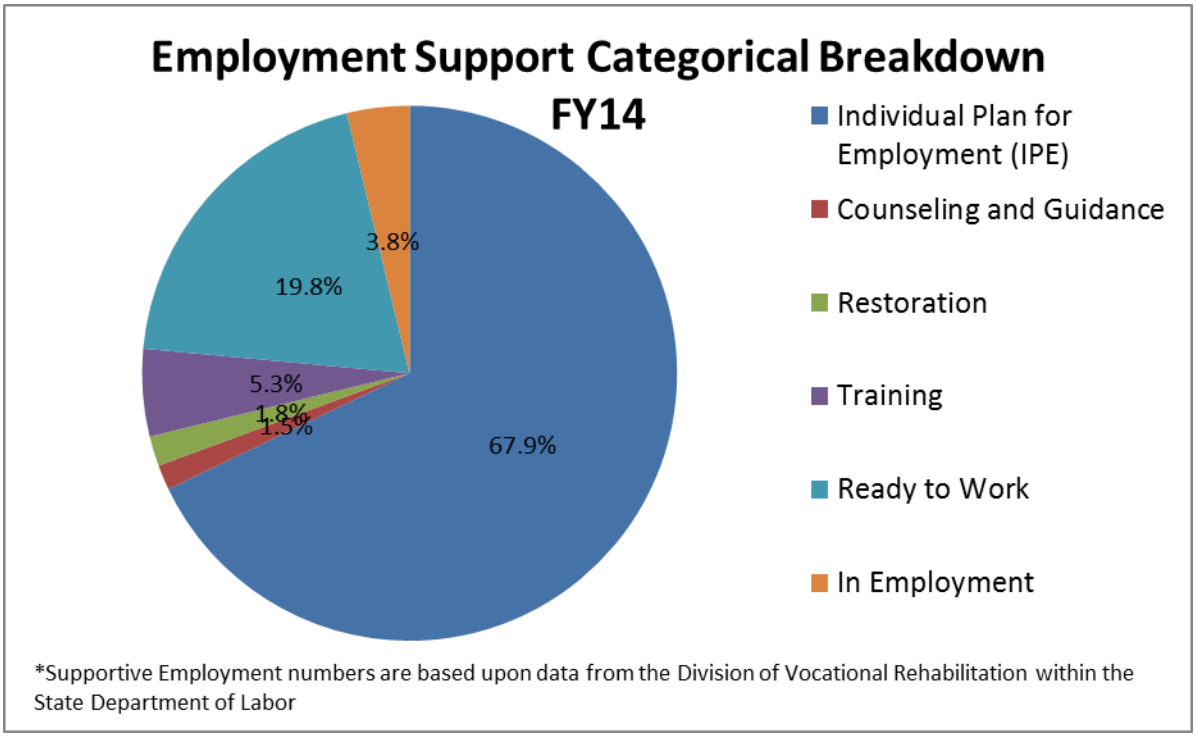
FY14: The Target was 100 units which were funded by SRAP

Supported Employment – Targets by Fiscal Year

- By July 1, 2012: The State will provide supported employment to 100 individuals per year. ***Substantial Compliance***
- By July 1, 2013 (FY12): The State will provide supported employment to 300 additional individuals per year. ***Substantial Compliance***
- By July 1, 2014 (FY12): The State will provide supported employment to 300 additional individuals per year. ***Substantial Compliance***

Substantial Compliance

"Section III.J.2 of the Agreement requires the state to provide supported employment services to an additional 300 individuals. DSAMH continues to have a strong partnership with the State's Division of Vocational Rehabilitation, which places a strong emphasis upon people with SPMI entering the mainstream workforce. As of the end of FY14 663 individuals were being served…" Court Monitor's Report December 29, 2014 Page 36.



*Supportive Employment numbers are based upon data from the Division of Vocational Rehabilitation within the State Department of Labor

Rehabilitation Services

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

Substantial Compliance

"Section III.K.2 of the Agreement requires the State to provide rehabilitation services to an additional 500 individuals by July 1, 2013, bringing the total requirement to 1,100. Rehabilitation services comprise an array of

activities, such as education, substance abuse treatment, and recreational activities.

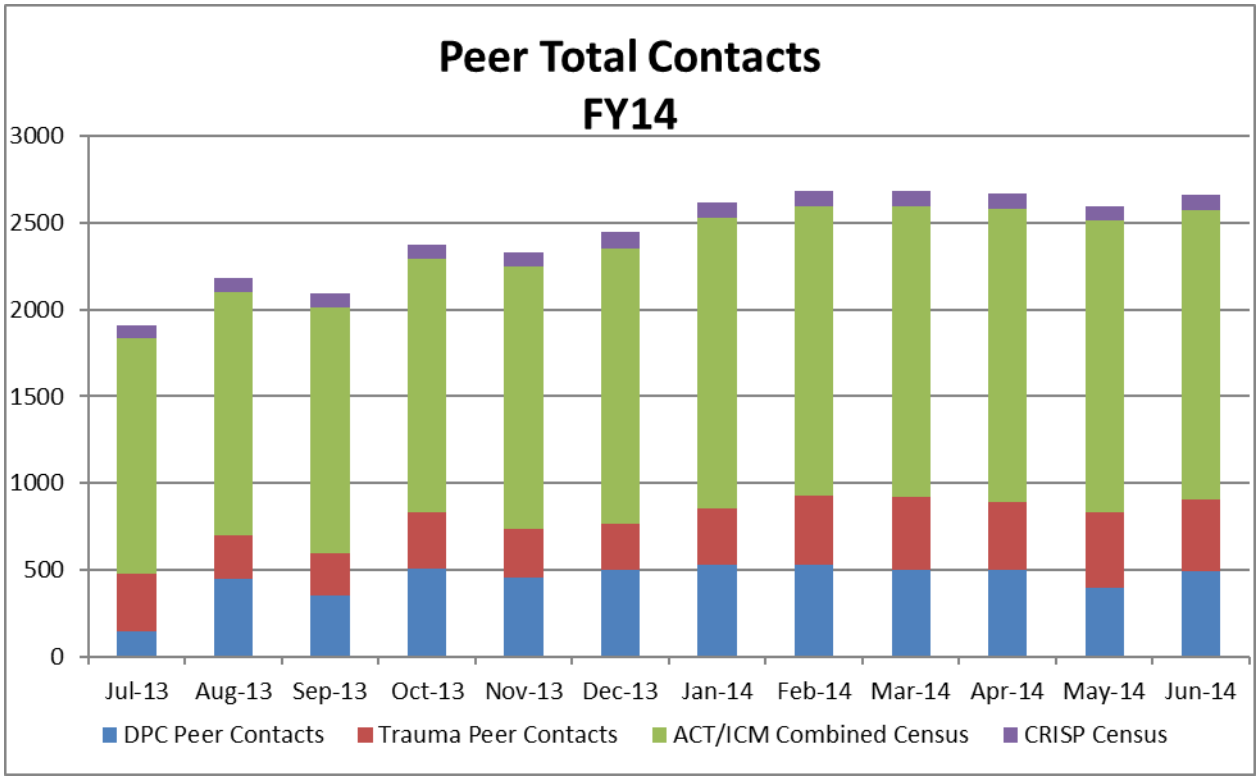
The unduplicated count is 1,222 persons receiving Rehabilitation Services.

Family and Peer Supports

- By July 1, 2012, the State will provide family or peer supports to 250 individuals per year.
- By July 1, 2013, the State will provide family or peer supports to 250 additional individuals per year.
- By July 1, 2014, the State will provide family or peer supports to 250 additional individuals per year.

Substantial Compliance.

Section III.L.2 of the Agreement requires the State to provide family or peer supports to an additional 250 individuals, bringing the total receiving this service to 750. The State has surpassed its requirements with respect to this provision, providing family and peer supports to peers and families that constitute more than 2,500 contacts in FY14.



APPENDIX II

FINAL REPORT OF THE HJR 17 CIVIL MENTAL HEALTH LAW STUDY GROUP

Introduction

The 146th General Assembly considered and passed HB 311, modernizing how people in Delaware are held involuntarily for a mental health evaluation. During the discussions of HB 311, it became apparent that Delaware's civil mental health laws (Title 16, Chapters 50 and 51 of the Delaware Code) had not been comprehensively reviewed in decades and since that time there have been substantial advancements in the treatment and care of persons with mental conditions. HJR 17 was passed because the General Assembly recognized that it is in the best interest of Delawareans that people be able to access the most appropriate mental health treatment, in the most appropriate but least restrictive setting, at the most appropriate time; and there are many opinions on how to best achieve the intended result of excellent clinical care while being attentive to and respectful of every person's civil rights.

HJR 17 further set forth that the State of Delaware is committed to modernizing and improving access to care, treatment, and housing for people with mental conditions and created a diverse study group ("Study Group"). The Study Group had two charges. The first was met last year when the Study Group reported its findings and recommendations as to the immunity provisions of 16 Del. C. § 5122(j) and 16 Del. C. § 5004(f) to the Speaker of the House of Representatives and the President *pro tempore* of the Senate. Those recommendations, contained in HB 9, represented a consensus agreement of the diverse stakeholders and were enacted by the General Assembly and the Governor.

This report represents the work of the second charge, which was for a Study Group to conduct a comprehensive evaluation of Delaware's civil mental health laws, set forth in Chapters 50 and 51 of Title 16 of the Delaware Code, and to make recommendations for improvement.

The members of the Study Group spent considerable time and energy meeting and drafting these recommendations. I cannot adequately convey the amount of time that members spent, over and above their regular job duties. Discussions included diverse stakeholders, and all meetings were held in compliance with open meeting laws, allowing for participation by the public throughout.

As such, the Study Group included both officially appointed members and members of the public. The appointed members were as follows:

Rita Landgraf, Secretary of the Department of Health and Social Services, Chair;
Susan Cycyk, designee of the Secretary of the Department of Services for Children, Youth and Their Families;
Ilona Kirshon, designee of the Attorney General of Delaware;
Kevin Huckshorn, Director of the Division of Substance Abuse and Mental Health;
The Honorable Jan Jurden, designee of the President Judge of the Superior Court of Delaware;
Dr. Harold Rosen, designee of the President of the Medical Society of Delaware;
Dr. Ranga Ram, designee of the President of the Psychiatric Society of Delaware;
Brenda K. Pierce, designee of the President of the Delaware Healthcare Association;
John McKenna, a representative from a designated psychiatric facility;
Sarah Fishman Goncher, designee of the President of the Delaware State Bar Association;
Rosanne Faust, a community provider;
James Lafferty, a representative of an advocacy organization;
Dr. Richard Kingsley, designee of the President of the Delaware Chapter of the American Academy of Child & Adolescent Psychiatry;
Dr. Jonathan McGhee, President of the Delaware Chapter of the American College of Emergency Physicians;

Representative Debra Heffernan;
Senator Margaret Rose Henry;
Bryce Hewlett, an individual appointed by the Governor from the public at large who is in recovery from experience with severe mental illness; and
Timothy Lengkeek, President of the Delaware Trial Lawyers Association.

The officially appointed members of the Study Group were fortunate to be joined by a diverse group of stakeholders representing mental health professionals, attorneys, and advocates. These additional members of the Study Group included the following:

Dr. Joshua Thomas-Acker
Dr. Neil Kaye
Andrew Wilson, Esq.
Meredith Stewart Tweedie, Esq.
Dr. Rich Bounds
Jean-Charles Constant
Debra Crosson
Steve Dettwyler
MaryCarol Beard
Aaron Goldstein, Esq.
Al Irvin
Amy O'Dell, Esq.
The Honorable Lynne M. Parker
Rosanne Faust
William Mason
Marissa Band, Esq.
Deborah Gottschalk, Esq.
Cheryl Heiks
Tara Harvey
Frann Anderson
Representative Michael Barbieri
Dr. Dyanne Simpson
Chuck Tarver

Given the enormity of the second task, the Study Group broke into sub groups to go into detail between larger meetings of the Study Group. The sub groups were under the topics of Due Process, Definitions, Out-Patient Commitment, Youth, and Intersection with Criminal Law. After a few months, the Due Process, Definitions, and Out-Patient Commitment sub groups merged into one sub group because there was so much commonality in group membership and in the topics being discussed. The work of the sub groups was presented at the meetings of the full HJR 17 Study Group. The recommendations presented by each sub group were adopted by the Study Group. These recommendations are summarized below and attached in full.

HB 311 Implementation

The work of the Study Group was informed by the changes being made pursuant to HB 311. The length of time that the Study Group had to accomplish its task allowed it to be informed by the implementation of HB 311 and lessons being learned as a result of those changes. HB 311 modernized the process by which a person is held for an involuntary mental health evaluation. Prior to HB 311, any doctor in Delaware could sign an Order requiring a patient to be held involuntarily for 24 hours for a mental health evaluation. People subject to this Order, or being considered for one, were taken by police to hospital Emergency Departments in handcuffs.

HB 311 changed the law so that only psychiatrists and credentialed mental health screeners could order someone held for an involuntary mental health evaluation. The Department of Health & Social Services, through the Division of Substance Abuse and Mental Health (DSAMH), implemented regulations, crafted in consultation with stakeholders, to set forth more fully the qualifications and training necessary for credentialed mental health screeners. Credentialed mental health screeners include licensed psychiatrists or mental health professionals, physicians, nurses, and unlicensed mental health professionals working under the direct supervision of a psychiatrist. Important components of the training include determining when someone is a danger to themselves or others, as well as familiarity with community-based treatment options and an understanding of how to assess and place people in the least restrictive environment. Credentialed mental health screeners already work in the health care community and can evaluate the person where the symptoms are presenting, rather than requiring transport to a hospital.

Since HB 311 was signed into law in July 2012, 289 mental health screeners have been credentialed: 136 Emergency Department physicians, 13 psychiatrists, and 140 other mental health professionals. These Credentialed Mental Health Screeners work throughout the community, including on DSAMH Mobile Crisis teams, emergency room physicians and nurses, and on the staff of private psychiatric facilities. The regulations also allow DSAMH to review decisions to make sure people were placed appropriately. HB 311 has only been fully implemented since July 1, 2013. Thus it is too early to evaluate if HB 311 is working as planned to limit involuntary inpatient mental health evaluations to those who really need them. However, preliminary data comparing the number of year-to-date detentions to the data for the same months last year shows a significant decrease in the number of involuntary detentions. HB 311 expands the locations where psychiatric evaluations can be performed. Prior to HB 311, hospital emergency departments saw all of these patients and have a rate of hospitalization of 90%. In contrast, only 21% of people being evaluated at the designated psychiatric assessment center are being hospitalized. Instead, people are receiving treatment voluntarily and in less-restrictive settings. Further, at least one hospital is reporting a 50% decrease in the number of individuals seeking help with behavioral health conditions in the emergency department because individuals in need of mental health treatment are being evaluated and linked to treatment through other settings. In addition to reviewing forms used by the Credentialed Mental Health Screeners, DSAMH is also developing Utilization Review methodology and appeals process to be used for all private psychiatric hospital admissions.

Due Process/Definitions/Outpatient Commitment

These are the core recommendations being made by the Study Group. The first is to combine Chapters 50 and 51. This decision was easily reached early in the process. The benefits to combining the Chapters include consistent definitions; the creation of a logical and structured process, and future changes will not produce inconsistencies across different statutes. No downsides were identified.

Some of the proposed changes update language and definitions to reflect modern usage, current terms, and promote consistency across the Delaware Code. Many substantive changes were made to modernize procedures and provide better civil rights protections to patients. Much attention was paid to making a

consistent process, so that people enter civil mental treatment in a consistent manner with due process protections and that similar protections and treatment philosophies are applied across the different levels of treatment. The proposed changes to the Delaware Code are attached as Exhibit A.

The structure of the recommended combined Chapters 50 and 51 is as follows: Definitions, Voluntary Admission, Emergency Detention, Provisional Admission, Probable Cause hearing, Involuntary Inpatient Commitment hearing, Involuntary Outpatient Treatment over Objection, Forced Treatment, Immunity, Discharge Planning, and Miscellaneous provisions.

Some important new terminology was added. New defined terms include the following:
"Voluntary patient" means a person who voluntarily seeks treatment at, and is admitted to, a designated psychiatric treatment facility or hospital for inpatient treatment of a mental condition.
"Psychiatrist" means an individual who possesses a valid State of Delaware license to practice medicine and has completed a residency training program approved by the Accreditation Council for Graduate Medical Education in Psychiatry. The Study Group revised definition of "credentialed mental health screener" to incorporate new definition of psychiatrist Renamed "24-hour Detention" to "emergency detention" or "emergently detained" to better capture procedures which apply to minors.

The voluntary admission process was revised to require a clearer showing of informed consent by the individual requesting to be voluntarily admitted, including having the admitting hospital or designated psychiatric treatment facility provide the individual with written explanation of legal consequences of voluntary admission. The proposal also reduces the timeframe to discharge a voluntary patient who requests discharge in writing from the current 5 working days to 72 hours.

The emergency detention process was left largely unchanged due to the recent update by HB 311. Some non-substantive changes are proposed to reflect new terminology, or provide clarity, and the "expert panel" created to draft the implementing regulations was removed because the regulations it is charged with writing have been enacted and the "expert panel" no longer serves a purpose.

Significant changes are proposed for provisional admissions. These changes would modernize the provisional admission process and strengthen civil rights. The proposal broadly adds additional safeguards to criteria and removes the ability to provisionally admit someone based on property destruction; it removes the ability of psychiatrist to bypass emergency detention through the use of provisional admission; it adds in *explicit* language that an individual who is provisional admitted shall be not considered "involuntarily committed" for any legal purpose; but it keeps the current time frame for provisional admission, allowing for 48-hour admission following a 24-hour emergency detention. Under the proposal, the revised standard for provisional admission would be that:

> No person shall be involuntarily admitted to a hospital as a patient until the person is detained for observation pursuant to the procedure set forth in Section 5004 of this Chapter. At the completion of the emergency detention period, the person shall not be admitted to a hospital except pursuant to the written certification of a psychiatrist that based upon the psychiatrist's examination of such person:
>
> > (1) Appears to be a person with a mental condition;
> > (2) The person has been offered voluntary inpatient treatment and has declined such care and treatment or lacks the capacity to knowingly and voluntarily consent to such care and treatment;
> > (3) As a result of the person's apparent mental condition, the person poses a present threat, based upon manifest indications, of being (i) dangerous to self; or (ii) dangerous to others; and

(4) Less restrictive alternatives have been considered and determined to be clinically inappropriate at the present time.

Revisions were made to probable cause hearing rules. The current time frame is retained with hearings to be held 8 working days after the hospital files a complaint in Superior Court. The proposal requires subsequent involuntary inpatient commitment hearing to be scheduled for "the earliest practicable date, and *no later than eight working days after the probable cause hearing*." It allows for hearings to be conducted using electronic means (permissive, not mandatory). It provides for increased privacy protections for individuals: spouse, close relative or friend no longer notified as matter of course, but only after individual is given opportunity to agree/disagree/prohibit/restrict such disclosure.

The sub group and Study Group devoted significant time to the involuntary commitment statute and some of the definitions relied upon for that process. The proposed involuntary inpatient commitment hearing and procedure statute outlines clear criteria that need to be established to involuntarily commit a person stating that:

(A) An individual shall be involuntarily committed for inpatient treatment only if all of the following criteria are met by clear and convincing evidence:

(1) The individual is a person with a mental condition;

(2) Based upon manifest indications, the individual is: (i) dangerous to self; or (ii) dangerous to others (the terms "dangerous to self" and "dangerous to others" were carefully vetted and tweaked by the subgroup);

(3) All less restrictive alternatives have been considered and determined to be clinically inappropriate at the time of the hearing; and

(4) The individual has declined voluntarily inpatient treatment, or lacks the capacity to knowingly and voluntarily consent to inpatient treatment. When determining evaluating capacity, the court shall consider an individual's ability to understand the significant consequences, benefits, risks, and alternatives that result from the individual's decision to voluntarily request or decline inpatient treatment.

The proposed statute provides clear due process protections after the involuntary inpatient commitment has been ordered, such as the requirement that the order not to exceed three months and shall be based on the court's individualized assessment of the facts and circumstances. At the end of the three month period, an individual is entitled to a hearing with at least a 14 day notice. If continued inpatient treatment is ordered, hearings are held every three months to review the case. The Study Group recommends a new definition of "dangerous to self" and "serious bodily harm." These new definitions reflect the current treatment standards.

A significant section of the proposal is the section on involuntary outpatient treatment over objection. This is an entirely new section of law that balances between doing away with outpatient commitment entirely and having an overly restrictive standard. It establishes specific criteria for outpatient commitment, but provides clinicians and the Court with a certain level of discretion. It explicitly provides for safeguards, such as consideration of all less restrictive treatment options, on the record findings of fact which support each criterion, clear and convincing evidence standard.

The Study Group also recommends changes to appeal and discharge rights. For appeals, the revised statute will better reflect Superior Court rules. The proposed revised language will require an individual to appeal a Commissioner's decision to a Superior Court Judge within 10 days of the entry of an order. Following a decision from a Superior Court Judge, an individual may then appeal the decision to the Supreme Court within

30 days. Under current law, an individual does not have to appeal a Commissioner's decision to a Superior Court Judge prior to filing an appeal with the Supreme Court. Thus, the current law is inconsistent with how other Court cases are handled.

For discharges, the Study Group recommends modified language so discharge requirements now explicitly extend to private psychiatric hospitals as well as DPC. This will not functionally change services already being provided by psychiatric hospitals because majority of what is covered by provision is already required elsewhere in Delaware Law. The Study Group proposal does recommend requiring an "examination" of every patient at least once every three months; provides that an individual may be discharged by his or her psychiatrist without further order of the court; and requires discharge planning.

Youth

The Study Group formed a separate subgroup to discuss youth. This subgroup did not start meeting until after the Study Group had a sense of how the recommendations on the adult system were developing. This way, the Youth subgroup was able to base recommendations for youth on what was being developed for adults.

The Youth subgroup proposes to add special provisions to Chapter 50, where the Subcommittee recommends different procedures for juveniles. It was recognized by the Study Group that youth need to be able to directly access treatment, but that treatment will usually involve the family.

Like with the adult system, due process protections were added for youth. Psychiatrists and specially trained credentialed mental health screeners will be the only people who can detain youth involuntarily for a mental health evaluation. However, because they are minors, consent for voluntary admissions to designated psychiatric treatment facilities or hospitals may only be given by a parent or legal guardian and such requests must be signed by a parent or legal guardian.

Once admitted, minors or their parents or legal guardians may make a written request to the psychiatrist to be discharged at any time. Discharge may be conditioned upon the consent of the parent or legal guardian. If the parent or legal guardian of a voluntary patient requests discharge against medical advice, the involuntary treatment procedures may be initiated.

The Study Group recommends that consent for voluntary outpatient mental health treatment for minors under the age of 14 requires the consent of a parent, legal custodian, or legal guardian. However, for minors age 14 to 18, the Study Group recommends that the minor or the parent / legal custodian / legal guardian may provide the consent. This is consistent with existing Delaware Law regarding consent to treatment for substance abuse services. If enacted, the consent of minors 14 and older will be treated the same as the consent of an adult with no other consent of another person or court being necessary to render treatment. However, the minors consent is not necessary if the parent/legal custodian / legal guardian has provided the consent. A minor, including those 14-18, cannot overrule consent provided by a parent/legal guardian / legal custodian. A parent/legal custodian / legal guardian may not abrogate the consent provided by a minor age 14 or older. Psychotropic medication requires the consent of the parent, legal guardian, or legal custodian.

Parallel to the adult system, the Study Group recommends that emergency detentions be done only by "Juvenile Mental Health Screeners." The proposed legislation authorizes the Department of Services for Children, Youth and Their Families to establish regulations concerning the credentialing process and criteria for Juvenile Mental Health Screeners. In addition, the Youth subgroup worked on a preliminary draft of a regulation detailing the required qualifications of Juvenile Mental Health Screeners. In addition, the Study Group recommends that the law allow that minors may be emergently detained with the parent/legal guardian is unwilling to provide consent or cannot be identified and located.

A different time frame is proposed for minors than adults for emergency detentions. When minors are emergently detained, the evaluation and treatment shall occur within 24 hours unless the parent or legal guardian is unavailable during that initial 24 hour period. In such instances the time period may be extended to 72 hours. Finally, the proposed legislation establishes the ability for the Secretary of the Department of Services for Children, Youth and Their Families to designate a psychiatrist or Institutional Review Board to review the emergency detention decisions of Juvenile Mental Health Screeners on an individual case or aggregate basis.

Intersection with Criminal Law

While outside the specific mandate of HJR17, the Study Group determined it was necessary to also look at criminal law and mental health because there is not a bright line separating treatment for mental health conditions, whether coming from civil or criminal courts.

A subgroup was formed to look at the intersection with criminal law. Draft legislation with the specific proposals is attached as Exhibit B. These provisions include recommendations to update antiquated language and make substantive changes to 11 *Del*.*C*. § 403, Not Guilty By Reason of Insanity; Commitment to Delaware Psychiatric Center and 11 *Del*.*C*. § 404, Incompetent to Stand Trial. Similar to the changes to civil statutes, these recommendations address due process issues and potentially unconstitutional practices currently in place.

Regarding the recommended changes to § 403: Verdict of Not Guilty By Reason of Insanity; Commitment to Delaware Psychiatric Center, the substantive recommendations include allowing the patient or DPC to petition for discharge at any time – eliminating the 1 year minimum requirement; streamlining the provisions in § 403(c) relating to petition filing requirements because currently, it is not clear whether they only apply to the outpatient treatment request petitions or also to the petitions for discharge; and allowing a patient who has been discharged from DPC and who has been subject to Superior Court oversight for 2 years to petition to discontinue oversight.

The substantive recommendations regarding 11 *Del. C.* § 404: Incompetent to Stand Trial Provisions insert a new provision governing the specifics of competency evaluations and mirrors juvenile competency restoration statute recently passed (10 Del C. § 1007A); mandate that a competency evaluation be held before person is confined to DPC to determine whether person even meets civil commitment criteria before admission; and allow a termination of competency restoration efforts after 2 years if, upon motion by DPC, the Court determines that competency restoration is not likely to succeed.

Operations

In addition to identifying statutory changes, some important improvements to the civil mental health system would be best made through operational changes. Main concerns were the amount of time people spend waiting in an Emergency Department to go to a Psychiatric Hospital and how people with actual or suspected psychiatric needs are transported. An operations subgroup was formed and prepared recommendations. A full report is attached as Exhibit C and suggests the following changes:

- Contract for transportation services to transport individuals from Emergency Department (ED) to Private Psychiatric Hospitals and discontinue use of Law Enforcement as transport unless necessary as a safety measure;

- Consider beginning psychiatric treatment in the ED;

- Consider and discuss advisability of extending Recovery Response Center services to New Castle and Kent Counties;

- Discharge Individuals from private psychiatric hospitals on weekends because necessary support services and resources are available (this has started);

- Develop short term beds (weekends) to accommodate individuals waiting for psychiatric beds at private psychiatric hospitals until such beds become available;

- Develop benchmark for an acceptable time frame for an individual in a psychiatric crisis to be held in the Emergency Department (Proposed 4.5-6 Hrs.);

- Once benchmark is set, monitor and report to Governor's Advisory Council quarterly on progress in meeting established benchmark;

- Consider establishing a service agreement or memo of understanding regarding the capability of providing both general medical and psychiatric care to individuals with complex medical conditions; and

- Consider development of peer services for hospital ED's and private psychiatric hospitals.

The Due Process/Definitions/Outpatient Commitment subgroup also submitted more operational suggestions that were adopted by the Study Group and are being implemented. These suggestions include a training requirement for all attorneys involved in civil mental health commitment hearings that cover an overview of common diagnoses and symptoms; sensitivity training regarding interaction with clients and their family members; ethical issues; a review of relevant statutes and litigation forms; and *Olmstead* and the DOJ Settlement Agreement. Also being implemented by DSAMH is increased information for consumers in the creation of consumer-oriented brochure on the commitment process; the insertion of Utilization Review nurses at all IMDs to audit patient records and protocols; and a toll-free community grievance phone number to assist consumers in the community with provider concerns.

Next Steps

The Study Group ran out of time to specifically craft proposed due process protections. It was decided that these protections should be added to the Mental Health Patients' Bill of Rights (16 Del.C. §5161). Additional protections regarding due process, including the involuntary administration of medication, fit within the Mental Health Patients' Bill of Rights and placement there will alleviate conflicts and confusion that would be created if they were instead put in the new Chapter 50. The Study Group wants to avoid having two different statutes address the same or related situations. A group will continue to work on language and present those recommendations separately. The Study Group agreed that due process protections could be strengthened, but doing so was complicated by the recent emergence of different models across the country and is too early to know how well each is working to decide what should be adopted in Delaware. The Study Group was comfortable continuing discussions because the system is currently working with protocols in place and in emergencies, going to Court. Similarly, the Study Group was unable to reach a recommendation on how to create due process in the 24 hour emergency detention process due to the short duration of the detention. Discussion will continue and will be informed by the review of involuntary detentions being conducted by the Utilization Review nurses and DSAMH.

Respectfully Submitted,

Rita M. Landgraf
Chair, HJR 17 Study Group

Exhibits

A. 2013-12-2 Draft Chapter 50-51-1

B. FINAL DRAFT dated December 19, 2013 of HJR 17 Criminal Mental Health Intersection Committee

C. Report of the Operations Subcommittee FC 2-1 3

APPENDIX III- PEER SUPPORT PROGRAM EFFICIENCY AND EFFECTIVENESS

Qualitative and Quantitative Measures to Assess the Efficiency and Effectiveness of the Peer Support Program at Delaware Psychiatric Center

Danielle Hinchey, MPH; Kris Fraser, MPH; Michelle Thompson, MS; Karen DiNardo, BA

Division of Substance Abuse and Mental Health; Delaware Department of Health and Social Services

BACKGROUND

- In 2011, Delaware Psychiatric Center (DPC) reached a landmark agreement with the United States Department of Justice that addressed the delivery of care to Delawareans with severe and persistent mental illness. Peer Support (PS) at DPC originated from this USDOJ agreement. As a result of the agreement, a federal grant was provided that supported the development of the PS program at DPC.
- There has been recent pressure from funding agencies to quantitatively justify PS Program effectiveness in order to preserve funding sources. [7]
- In a proactive effort, PS worked with Performance Improvement (PI) to initiate the Peer Support Project in an effort to identify tools for program evaluation, as these tools would have the capacity to justify the program for the continuation and potential expansion of the PS program at DPC. [7]
- PI recognized that while PS is skilled at presenting qualitative measures, they had not formalized procedures for collecting and analyzing quantitative data. Therefore, PI became involved with the project to help strengthen aspects of the program using evidence-based evaluation.

Figure 1. A DPC Peer Support Specialist chatting with two clients

METHODS

- Consulted with stakeholders to identify a program evaluation framework.
- Researched and interviewed existing PS Programs for benchmarking purposes. Researched the kinds of tools these facilities use to track performance.
- Used information from existing PS programs to inform the development of DPC's PS performance measures and assessment tools.
- Presented pilot measures and assessment tools to stakeholders for approval and continually revised according to feedback and changing needs.

PRODUCTIVITY REPORT

- Allows supervisors and managers to have a clear idea of Peer Specialists' time usage presented in a standardized manner. Additionally, allows management to make more informed decisions about human resource allocation.
- This tool would be used to coordinate PS activities and mentor Peer Specialists' on time management, which in turn may have beneficial effects on job tension and satisfaction. [4]
- Productivity measuring is an organizational tool that is standard in manufacturing services and has become increasingly popular in the health care field. The goal of measuring productivity from a system level is to determine how resources are apportioned with an eye towards improving efficiency. [9]
- It was developed as a tool that can be standardized and adopted by other PS programs with the hope that this information (i.e., utilization rate) can be communicated in a universal language. This would allow for benchmarking among programs and further develop the field as a whole. [2]
- While we ultimately intend to have an outcome measure for the productivity report, PS is still in the process of collecting baseline information that will inform what the outcome measure should be.

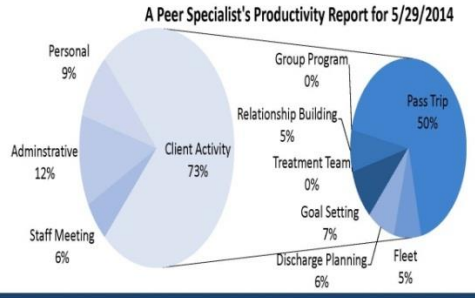


Figure 2

PROGRAM SATISFACTION SURVEY

- Enables PS to have an objective understanding of client program satisfaction. Participation has been shown to benefit clients in many ways, including increased self-esteem and development of new skills. [3]
- This standardized, evaluative tool will allow PS to collect data that will be used to make evidence-based quality improvement decisions to their program. [5]
- DPC's PS program assessed the Peer Outcomes Protocol (POP) questionnaire and the program satisfaction survey was modified based on the POP questionnaire. Dr. Jean Campbell developed the POP questionnaire after her and her staff at the University of Chicago surveyed 40 PS programs across the country to understand their programmatic needs. [1]
- The Program Satisfaction Survey will determine if PS is meeting the following performance indicators:
  1. Achieve at least 80% client satisfaction
  2. Increase awareness of mental health services in Delaware
  3. Build relationships between peers and clients

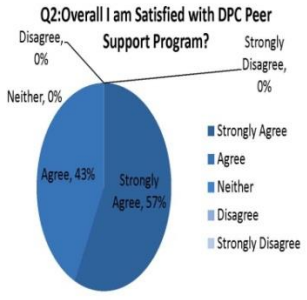


Figure 3

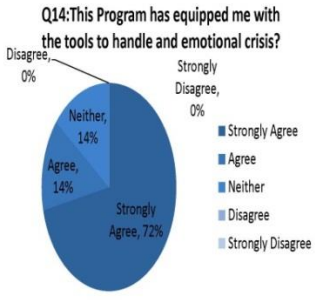


Figure 4

DISCUSSION

Potential Issues with Self-Reporting Productivity

- Recall bias can be an issue that can affect the validity of findings. This is of particular importance when the recall period is longer.
- Respondent burden (i.e. the ease of use of the instrument) can also affect validity of the data. If the respondent burden is too high, participants may not be inclined to give accurate reports.
- Respondent may also be affected by self-report bias related to reporting socially desirable/undesirable behavior. [6]
- Underutilization of technology by people with intellectual and developmental disabilities are attributed to barriers of use (cost and training) that may impact both Peer Specialists and the clients they serve. As DPC's PS seeks to transition from paper-based assessments and evaluations, extensive training and support will be required to ensure a smooth transition. [8]

Program Satisfaction Survey Barriers to Implementation

- *Scheduling Participation*. Program Evaluation Survey is based on a client's discharge readiness, which leaves Peer Specialist with a small window of time in which to administer the survey. This has led to missed opportunities to administer the survey. Capturing the data for all discharge ready clients has proven difficult.
- *Gaining Staff Cooperation*: PS Specialists are skeptical as to whether clients are capable of participating in the Program Satisfaction Survey, as many of them believe that the survey is too long and the language is too complicated for the clients to understand.
- *Extensive Staff Time Commitment*: PS acknowledges that including clients in evaluation requires a time commitment (i.e. time to train Peer Specialists, time to interview clients, time to analyze data etc.), which has been a barrier to implementation given that PS is still expected to maintain their standard task load. [3]

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