

**Fourth Progress Report on  
Implementation  
of the Settlement Agreement  
Between the U.S. Department of Justice and the  
State of Delaware**

**June 2016**



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**DELAWARE HEALTH AND SOCIAL SERVICES**

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**Division of Substance Abuse and Mental Health**

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1901 North DuPont Highway, New Castle, Delaware 19720

**Published by the Division of Substance Abuse and Mental Health  
1901 North DuPont Highway  
New Castle, Delaware 19720  
March 2016**

June 2016

Dear Citizens of Delaware,

As we approach the end of the final year 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. Building a more robust public mental health system for Delaware is not solely about meeting the legal goals laid out in the agreement. For the Department of Health and Social Services (DHSS) and the State of Delaware this is about serving our neighbors, friends and family members with serious and persistent mental illness and building a system of care that is able to meet their needs in the community for decades to come.

We would not have made the progress we have without the ongoing support of the U.S. Department of Justice, Court Monitor Dr. Robert Bernstein, Gov. Jack Markell and his staff, the General Assembly, the staff of DHSS and, in particular, the teams within the Division of Substance Abuse and Mental Health (DSAMH) and the Delaware Psychiatric Center (DPC), community partners, advocates, families, and individuals with serious and persistent mental illness. We are grateful to all of the stakeholders who have contributed in many ways to the reform effort we have undertaken as a state. Sometimes, the simplest words are also the most powerful, so we offer these: Thank you.

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 community services in place to meet the needs of Delawareans with serious and persistent mental illness (SPMI), the providers and staff who carry out the care and other services, and the systems in place to monitor and evaluate the quality of the services provided. Every day, we see the benefits of the community-based system when individuals with SPMI are able to engage in a full life in the community, to find meaningful employment, to live in their own home with appropriate supports, and to share their gifts with others and vice-versa. An inclusive Delaware is a stronger and better Delaware.

While we have made considerable progress over the past five years, we know there are still more challenges to overcome as we embed inclusion and the benefits of diversity as core values in our state. We expect the robust community-based mental health care system that we have built together will serve and to continue to evolve for Delawareans with serious and persistent mental illness for decades to come. For the consumers and stakeholders who have contributed so much, we believe that would be an appropriate and lasting legacy.

We encourage you to contact us with questions, concerns or comments.

Sincerely,

*Rita Landgraf*  
Cabinet Secretary  
*Delaware Department of Health and Social Services*

*Michael Barbieri*  
Director  
*Division of Substance Abuse and Mental Health*

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## SECTION I: INTRODUCTION AND OVERVIEW OF THE SETTLEMENT AGREEMENT

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 USDOJ sued the State of Delaware because of a 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 describing the following:



*"The State will publish an annual report identifying:*

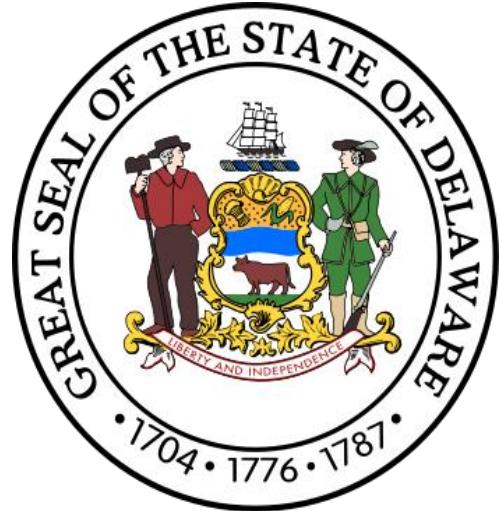
- *The number of people served in each type of service described in the agreement;*
- *Unmet needs using data gathered during admission assessments, discharge planning process and community provider reports; and*
- *The quality of services provided by the State and the community providers using data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

This is the Fourth Annual Report issued by the Department of Health and Social Services (DHSS) on behalf of the State of Delaware.

The First Annual Report was issued in May 2013 and covered the first 18 months of the Settlement Agreement. The Second Annual Report was issued December 15, 2013, and 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 included the overall accomplishments in year two of the Settlement Agreement.

The Third Annual Progress Report was based on programs that were developed and implemented by the Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) and the Division of Substance Abuse and Mental Health (DSAMH). DHSS and its divisions, which have clients who are part of the target population defined in the Settlement Agreement, continued to strengthen the foundation of the new mental health system, and develop and implement new programs and procedures that supported the concept of community service delivery to persons with a mental health disability.



#### The Third Annual Report featured:

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 embraces the initiative of Governor Markell for the State to hire persons with disabilities.

#### The Fourth Annual Report focused on the following:

- The recommendations for the State contained in Eight Reports issued by the Court Monitor throughout the course of the Settlement Agreement. In addition to meeting the vast majority of the benchmarks contained in the Settlement Agreement, the State has also achieved many of the Court Monitor's supplemental suggestions for systems change in Delaware.
- The outcomes from implementing the revised legislation that affects civil commitment and the success of the community support services to prevent multiple hospitalizations.
- The cost benefit of serving clients in the community through permanent housing, community services and 23-hour crisis intervention, instead of serving clients in the psychiatric hospitals including DPC.
- The sustainability of the new services through State budgeting and leveraging with federal dollars.
- The analysis of community mental health services, CRISP, ACT and ICM spearheaded by University of Pennsylvania Center of Mental Health Policy and Services Department of Psychiatry.

#### The content is divided into the following sections:

- Section I: Introduction and Overview of the Settlement Agreement;
- Section II: Status of the Court Monitor Recommendations found in the Eight Reports;
- Section III: State Commitment to Funding Sustainable Mental Health Services;
- Section IV: University of Pennsylvania Evaluation of Community Mental Health Services;
- Appendix I: Status of the Settlement Agreement Targets for FY15; and
- Appendix II: List of all recommendations by report in descending order.

## **SECTION II: STATUS OF THE COURT MONITOR RECOMMENDATIONS FOUND IN THE COURT MONITOR REPORTS THROUGH THE EIGHTH REPORT**

The Court Monitor is required by the Settlement Agreement to document the progress of the State every six months. Settlement Agreement Section VI. Monitor and Monitoring B. 2. "The Monitor shall have the authority and responsibility to complete the following actions: b. At least twice a year draft and submit to the parties and the Court a comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance...."

This Fourth Progress Report is based on the eight reports written by the Court Monitor (the Eighth Report was completed by the Court Monitor on December 26, 2015, and covers the progress of the State over the four fiscal years ending June 30, 2015).

The Court Monitor has consistently included recommendations in each of his reports. As would be expected, the number of recommendations per report has lessened over the four years. The eighth report did not have any recommendations and the seventh report had two recommendations. Compare that to the seven sets of recommendations from the first and second report in year one.

Overall, the recommendations are beyond the scope of the Settlement Agreement targets. They typically offer additional guidance to expanded services and improve the foundation of the service delivery system while the State implements the targets. Recommendations can be found when the Court Monitor believes additional programming would be an enhancement, as well as when the State is not meeting the targets of the Settlement Agreement.

At the beginning of the five-year Settlement Agreement, the first and second Court Monitor reports had seven sets of recommendations. The third report had six sets of recommendations and each report thereafter had fewer recommendations. The seventh report had two sets of recommendations, indicating that the State is well on the way to finalizing its mental health system reform and fewer foundational suggestions to be made or implemented. The eighth report did not have any recommendations. The entire list of recommendations can be found in Appendix II of this report.

The primary recommendations in the reports are in the following subject areas:

- Use of Data
- Supported Employment
- Crisis Services
- Civil Commitment

This Annual Report highlights the four reoccurring subject areas and the efforts made by the State to implement the recommendations consistent with the State redesign of the mental health system.

## **USE OF DATA:**

*Settlement Agreement Section V. Quality Assurance and Performance Improvement E. Use of Data (page 18):*

1. "The State shall collect and analyze data from assessments of the most integrated settings appropriate, including data about barriers to service, in order to refine Olmstead planning and determine whether additional specialized services are needed.
2. The State shall ensure that every community service provider assesses the adequacy of the individualized supports and services provided to persons in the target population by collecting and analyzing data, including, but not limited to:
  - a. Number of incidents of harm;
  - b. Number of repeat admissions to DPC, an IMD or other inpatient psychiatric facilities;
  - c. Use of crisis beds and community hospital admissions;
  - d. Repeat emergency room visits;
  - e. Number of arrests and incarcerations;
  - f. Time spent in congregate day programming;
  - g. Number of people employed, attending school or engaged in community life;
  - h. Acquisition of life skills; and
  - i. Maintenance of a chosen living arrangement."

In July 2011 when the State signed the Settlement Agreement, the Division of Substance Abuse and Mental Health (DSAMH) had a working system of data collection and analysis. DSAMH did not have an electronic health records system, and had limitations in human resources that could be dedicated to transforming the data into management decision-making information. In both the third and fourth reports, the Court Monitor reported on the *Use of Data* addressing the lack of staff, process for data collection and analysis, and the coordination and implementation of the information that was available from analyzing the data.

Specifically, the Court Monitor pointed out the following:

- The lack of up-to-date information technology systems to collect the data;
- The fragmentation between DSAMH units, DHSS Divisions and State Agencies in collecting data;
- The lack of analysis of the data; and
- The lack of use of data as a management tool to understand current trends and forecast future outcomes.

Below are the Recommendations from both the third and fourth Reports from the Court Monitor:

### **Third Report: March 8, 2013**

*Data Systems – Recommendation: Page 3 line 99:*

"... today's information technology has not been meaningfully embedded. ... It is very important that DSAMH have the analytic expertise to integrate both information and service delivery elements. The recommendation to bring staffing capacity to DSAMH to allow for such analytic expertise..."

### **Fourth Report: September 24, 2013**

*Use of Data – Recommendation: Page 8 line 238:*

"DSAMH has improved its data collection and data-driven oversight of services ... DSAMH remains significantly limited in its ability to produce and appropriately analyze data in ways it will maximize its performance. ..."

### ***Staffing and Unit Reconfiguration***

DSAMH has entered into a partnership with the Information Resource Management (IRM) unit within the Division of Management Services to implement a system-wide electronic health record and modern-day data storage mechanism.

Specific recommendations from the expert consultant's report included the following about DSAMH's data needs:

1. Continue to work with other state agencies, including the Department of Justice, and Department of Correction to find solutions to data-sharing restrictions and establish MOUs around sharing client-level data. (J. Yoe, 2012)
2. Initiate formal IT assessment of current data systems for recommendations on a system redesign to meet current needs and upgrading of technology. (J. Yoe, 2012)
3. Move forward with plan for implementing an Electronic Health Record (EHR) across the MH/SA system starting at DPC and State CMHCs. (J. Yoe, 2012)
4. Review and realign MIS unit positions and functions to support new organizational unit and to eliminate inefficient and non-value added work. Redirect work away from data collection and data processing to analysis and reporting to support Division planning and decision-making. (J. Yoe, 2012)

As noted above, the current staffing complement in the old "Management Information Systems" unit of the division was not adequate to meet modern-day information needs. While the implementation of an electronic health record and data storage system is a positive step, the division needed to develop the analytics that are paramount in decision making relative to achieving and assessing outcomes.

The Management Information Systems (MIS) unit has restructured in response to the recommendations made in the Monitor's report. The unit has very purposefully moved from a reporting unit to an analytics unit. The restructuring started with a reclassification of the leadership position over that unit from a classification that focused on information systems and technology to a position that is a manager of statistics and research. This position now is filled, and the incumbent recently achieved a Six Sigma Lean Green Belt. Additional staff have been approved for the unit to provide greater analytic capacity.

### ***Data Collection, Presentation and Analysis***

The State has implemented a number of ways to collect and use data as required by the Settlement Agreement. The most obvious is that data collection is connected to targets in the agreement. The State began collecting data, as it relates to the targets, as soon as the target was in place. For example, the housing target for FY11 was 150 units (which were grandfathered in when the Settlement Agreement was signed) and for FY12 the target was 200 units. At the end of FY12, the State was able to demonstrate by funding source the number of housing units that were dedicated to the Settlement Agreement target and that the State had a total of 350 integrated units. At the end of FY15, the State met and surpassed the target of 650 units. Because of the data collection improvements, the State can report by funding source the location of each of the 650 units; the unit is integrated in the community; and the client has SPMI.

Over the four years of the Settlement Agreement, the data collection for the targets expanded as did the need to answer more questions, such as who was receiving services, how long did the services last and why did a person terminate services. Delaware had an interest and a need to expand the data collection beyond the

targets and created a subset of data and analysis that can assist in managing, planning and budgeting for future programs and services.

For example, the State has funded 377 State Rental Assistance Program (SRAP) vouchers and has been able to leverage the funding to finance an additional 98 vouchers for a total of 475. The State now has four years of data on the use of vouchers, including the amount of time it takes for a person to find and move into a unit, to the average length of stay in housing (when the client leaves the SRAP program). The information can be used for planning and budgeting for growth or sustaining the program. This data analysis is far beyond the requirement of the Settlement Agreement and can be used to inform leadership in Delaware and in other states how the voucher program works, who is most successful, what type of services are necessary to project success and why one person is successful and another is not.

The State began producing monthly reports by target area as defined in the Settlement Agreement in March of 2013. The first dashboard (Score Card) was designed during FY13 and FY14 was the first full year of complete data collection and Score Card Trending. There are two full years of data now that relate specifically to the Targets and several subsections of data that are an outcome of the primary data.

DSAMH also has a contract with the University of Pennsylvania, Center of Health Policy and Services, Department of Psychiatry (UPenn) to conduct an evaluation of the US DOJ Settlement Agreement in Delaware. This includes a review of the state's data, and specific analysis around the data. UPenn also has been involved in conducting research for the CRISP Program, as well as the Quality Review Program for the ACT and ICM Teams. *Section IV* of this report is a complete explanation and analysis of CRISP and QPR by UPenn. Additionally, in the *Third Annual Progress Report* issued by the State, UPenn provided an analysis of bed days from a cohort perspective using DSAMH and Medicaid data.

As noted above on Page 8 in “Use of Data,” the Settlement Agreement refers to the type of data that the State should receive from the service providers. Specifically, the State receives data on incidents of harm when it happens from the service provider. Additionally, on a monthly basis, the service provider sends the answers to the flowing questions to DSAMH:

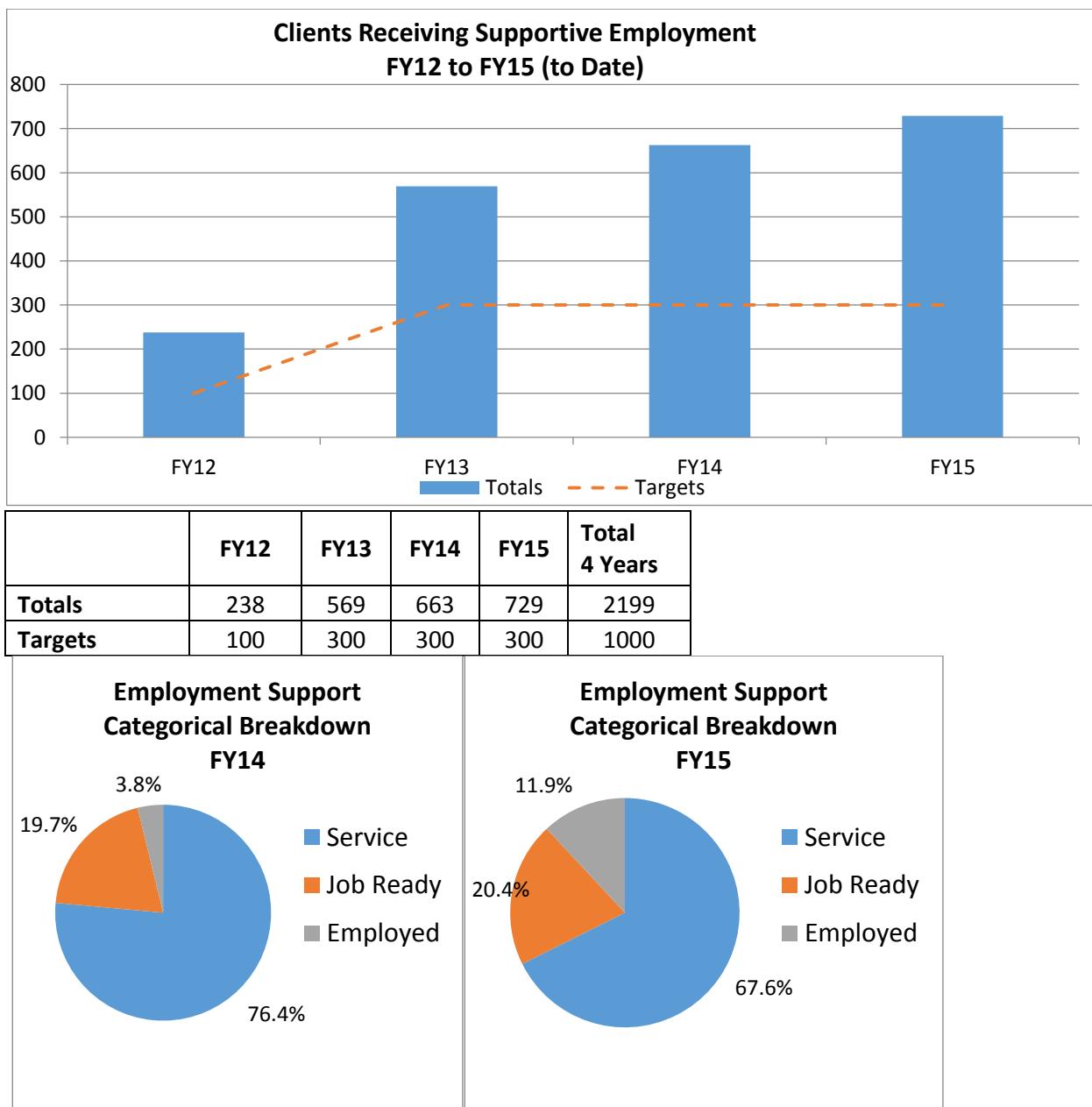
- Average homeless for any night during the month;
- Average of consumers arrested;
- Average of consumers hospitalized in a psychiatric hospital;
- Average number of psychiatric hospital patient days per month;
- Average emergency department visits;
- Average number of consumers admitted to a general hospital;
- Average number of consumers unemployed for any period during the month;
- Average number of consumers competitively employed <10 hours/ per week;
- Average number of consumers competitively employed 10-20 hours a week;
- Average number of consumers competitively employed 20+ hours per week;
- Percentage of consumers on an outpatient commitment during the month;
- Percentage of services provided in the community (outside the provider’s office) for the month;
- Total number of consumers served during the month; and
- Number of clients active in the system from the service provider perspective.

At the beginning of FY14, data were put into charts and shared with the DSAMH leadership and service providers. The data are trended for each service provider as well as a comparison of all the service providers. DSAMH now has two full years of data it can use as another tool for managing client services.

### **SUPPORTED EMPLOYMENT:**

In the *Settlement Agreement: II Substantive Provisions F. Supported Employment and Rehabilitation Services #2a. Supported Employment: i.* “Supported employment is a service through which individuals receive assistance in preparing for, identifying, attaining, and maintaining integrated, paid, competitive employment. ....” Page 9.

DSAMH has met the targets of supported employment every year of the Agreement. The charts below demonstrate the success the State has had in meeting the targets.



Although the State met the target consistently, the Court Monitor provided additional recommendations in the third, fourth and seventh reports to encourage the State to build on the basic fundamentals of providing supported employment services to clients. Below are the Court Monitor's recommendations:

### **Third Report: March 8, 2013**

*Supported Employment – Recommendation: Page 16 line 578:*

“ ... it has been understood that employment of people with SPMI can be realized if an expectation of work is better embedded in the service organization of providers. ... The Monitor is planning a series of additional meetings with DSAMH and DVR to chart out a course towards an “employment first” model.”

### **Fourth Report: September 24, 2013**

*Supported Employment – Recommendation: Page 27 line 805:*

“.... the redesign for ACT to TMACT as complete and with the redesign it was recommended by the Court Monitor to dedicate one position within the TMACT positions to supported employment ...”

### **Seventh Report: June 11, 2015**

*Supported Employment - Recommendation: Page 13 line 373:*

“ ... While the job market remains competitive, the State has indicated it could likely achieve even further improvements if additional trained employment specialists were available to work with the targeted population and prospective employers. ... While the State is in Substantial Compliance with supportive employment ... it is an outcome that goes to the core of the Settlement Agreement intent. ... It is recommended that the State consider an expansion in the number of trained employment specialists working with the target population. ”

The State has advanced supported employment services not only for persons with mental health disabilities but for the entire disability population in Delaware. The primary way Delaware has done this is through its participation as a “Core State” in the Employment First State Leadership Mentoring Program (EFSLMP), an initiative supported by the Federal Office of Disability Employment Policy (ODEP). The key objectives of the EFSLMP are to provide technical assistance and training, foster a community of practice, and link states with federal initiatives, which are focused on state-level, system-change efforts related to employment first values. Partners in this effort include representatives from the Department of Services for Children, Youth and Their Families, the state Department of Labor as well as from several divisions within DHSS, including the Division for the Visually Impaired, DSAMH, DMMA, Division of Management Services, DDDS, and Ability Network of Delaware (formerly known as Delaware Association of Rehabilitation Facilities (DelARF)).

USDOL-ODEP awarded the Employment First State Leadership Mentoring Project to the State in October 2013. The focus on expanded supports to persons with mental health disabilities began in the second year (October 2014), under the Vision Quest focus area to enhance state policies in this area.

As an EFSLMP core state, Delaware is a participant in ODEP’s EFSLMP Vision Quest (VQ) Policy Working Group Series. The states have been divided into four working groups based on their individual requested area of focus, including Rate & Reimbursement Structuring; Home & Community-Based Services; Workforce Innovation & Opportunity Act Implementation; and Mental Health & Employment Strategies. A summary of activities under the four goals of the Delaware EFSLMP is provided below:

Goal 1: Capacity Building

Goal 2: Provider Transformation

Goal 3: Performance Measurement

Goal 4: Policy/Funding Alignment

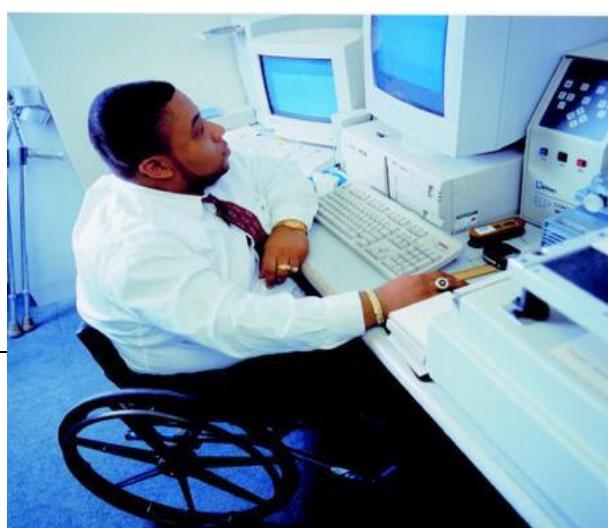
Under the goal of Policy and Funding Alignment, the Division of Substance Abuse and Mental Health is using the technical assistance opportunity under Vision Quest to focus on the implementation of supported employment within the context of its newly approved 1115 HCBS waiver, "PROMISE." Dr. Virginia Selleck has been assigned to assist the Division and the state to address policy areas for improving access to employment for persons with mental illness.

(Virginia Selleck, Ph.D., has worked in the rehabilitation field for over 30 years. She has experience in psychiatric rehabilitation program development, implementation, funding issues, legislation, and policy. Her Ph.D. is in Counseling Psychology from the School of Education and Social Policy, Northwestern University, and a Master's Degree in Rehabilitation Counseling from the Rehabilitation Institute, Southern Illinois University.

She is currently a Subject Matter Expert for projects funded by both SAMHSA and ODEP, and employed for special projects by Places For People, a Community Mental Health Center in urban St. Louis, Missouri, where she recently retired as VP of Clinical Services.)

In an excerpt from Dr. Selleck's Vision Quest reports (July 2015), she outlines the key policy areas to be addressed:

- "Insure that providers are well versed in the Fidelity standards for IPS and ACT. If the state is choosing to adapt any of these standards, policy documents for providers must be created, and fidelity reviewers trained. In particular, practices that will insure close collaboration between entities providing employment services should be illuminated, since this concept is one of the bedrock principles of the evidence-based practice of IPS SE.
- Clarify the braiding of funds between the PROMISE waiver, VR, and Mental Health Services for those persons not included in the waiver **in the realm of employment supports**. It is not likely that all persons served need the intensity of IPS SE, but providers need guidance about how to use the employment supports available to them. Particular emphasis on personalized benefits planning will be important.
- Develop a tiered approach to communicate revised policies and deliver technical assistance to the provider community. Targeted communication to provider leadership and managerial levels should insure that they understand and concur with the importance of employment as a primary lever of recovery. Line staff will need clarity on new or different expectations about their role in employment services and supports.
- The mental health provider system may benefit from refreshed information about the close link between employment and overall health and wellness. Unemployment in the general population is linked to many adverse consequences such as physical illness, social disconnection, domestic violence, and increased substance abuse, not to mention poverty, the number one social determinant of poor health.



To address the areas above that are consistent with the Settlement Agreement goals to extend access to supported employment for persons with mental illness, several workshops will be delivered over the fall of 2015 and a follow up workshop in the summer/fall of 2016. These workshops will be geared toward agency directors, ACT teams and ACT

team members: Recovery through Employment, (Importance of Employment) Perspective of Persons with Lived Experience, and Financial Strategies and DSAMH staff.

### ***CRISIS SERVICES:***

Crisis Services as defined in the Settlement Agreement includes:

- Crisis Hotline (call in to an 800 number operated 24/7);
- Mobile Crisis Services (Mobile Crisis team working with crisis on the phone or in the community at a person's home or other place where the person is having a crisis);
- Crisis Walk-In-Centers (Recovery Resource Center in Ellendale – 23-hour diversion);
- Crisis Stabilization Services (Service provider meeting the client at the hospital within 24 hours and reduction of bed days);
- Crisis Apartments (apartments for persons in crisis 3- to 5-day stay);
- Assertive Community Treatment Teams;
- Intensive Case Management Teams;
- Case Management;
- Supported Housing;
- Supported Employment;
- Rehabilitation Services; and
- Family and Peer Services.

Over the last four years, the Court Monitor has written about the challenges and successes the State has had in implementing "*Crisis Services*." There have been many successes, and Delaware consistently has met 95 percent of the targets as defined in *Crisis Services*. Beyond the successes, there have been some challenges and interpretations of the State meeting the targets. In only a few areas has the State not been rated in *Substantial Compliance*. (*Substantial Compliance* is an achievement rating defined in the *Settlement Agreement Section VI Monitor Powers and Responsibilities* page 22.) The lowest rating the State has received is Partial Compliance. The State has addressed every target to the best of its ability and continues to address the areas that are in Partial Compliance.

The recommendations below are about improvement of *Crisis Services*. They are not about implementation as much as they are about improving what has been implemented. In each case, the recommendation was implemented and is now embedded in the new mental health system.

#### **Second Report: September 5, 2012**

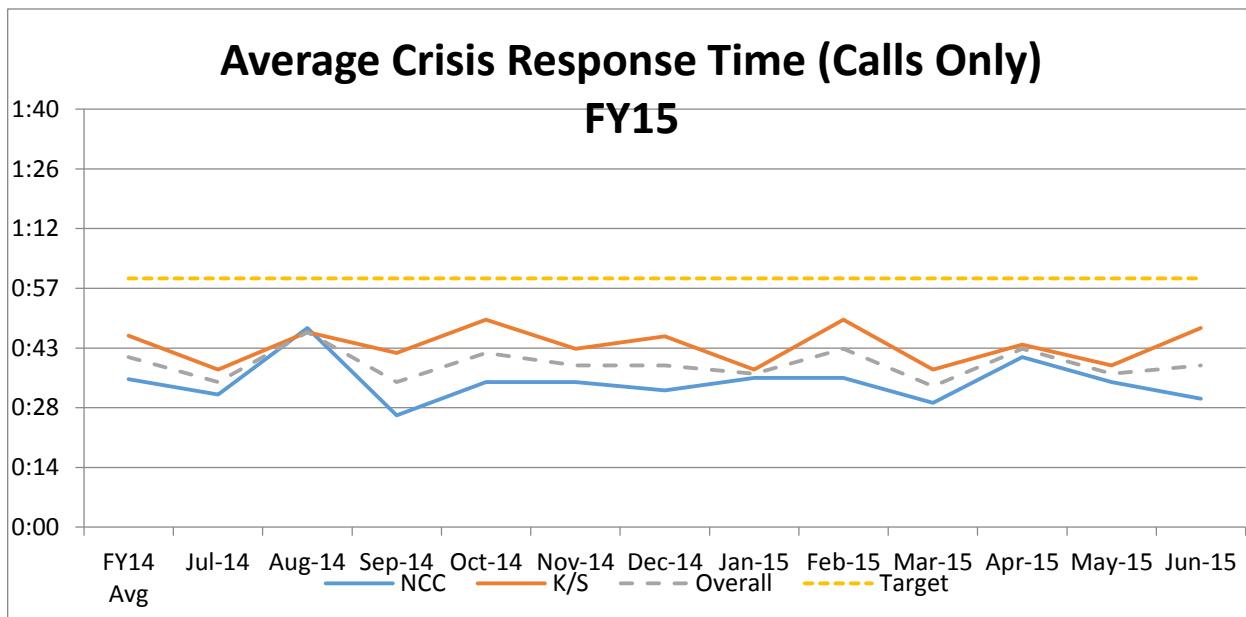
##### *Mobile Crisis Services – Recommendation: Page 13 line 463:*

"..., the State needs to improve its capacity for data collection and management including its ability to capture data reflecting the time between the receipt of a request for crisis intervention and the arrival of staff on the scene.

In order to ensure that resources are appropriately in place statewide, data relating to response times should be tracked on a county-by-county basis, including day, time of day and specific responders."

The State implemented a scorecard (sometimes referred to as a "dashboard") of the Settlement Agreement targets, including the time it takes for the Mobile Crisis Team to respond to a call. The State consistently has met the target of responding within one hour. In addition to maintaining a monthly record of the response time, the State can drill down on the data and determine the number of persons diverted from hospitalization, the

differentiation between mental health crisis calls and substance use crisis calls, and the disposition of a client. Below is an example of the Mobile Crisis dashboard:



	FY14 Avg	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
<b>NCC</b>	0:35	0:32	0:48	0:27	0:35	0:35	0:33	0:36	0:36	0:30	0:41	0:35	0:31
<b>K/S</b>	0:46	0:38	0:47	0:42	0:50	0:43	0:46	0:38	0:50	0:38	0:44	0:39	0:48
<b>Overall</b>	0:41	0:35	0:47	0:35	0:42	0:39	0:39	0:37	0:43	0:34	0:43	0:37	0:39
<b>Target</b>	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00	1:00

#### Third Report: March 8, 2013

*Transition Planning – Recommendation: Page 13 line 452:*

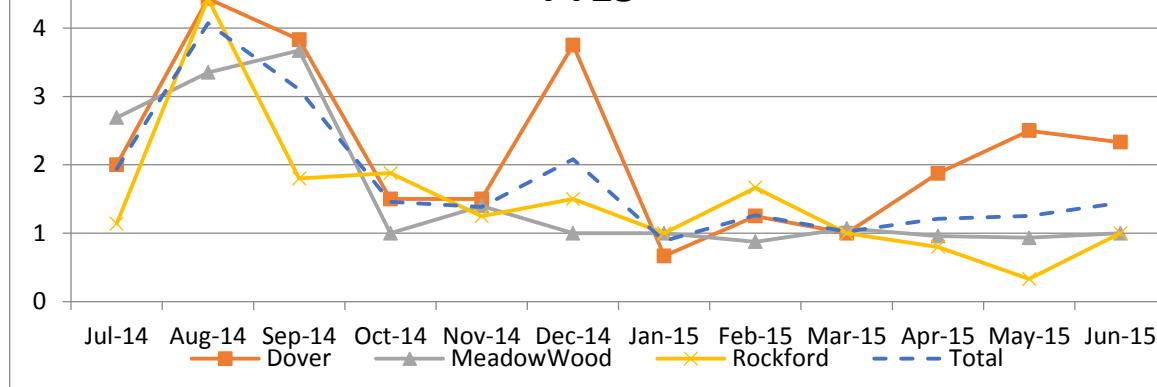
"The State should move quickly to ensure that the requirements of the Agreement relating to Transition Planning are extended to all individuals with SPMI who are admitted to an IMD under publicly funded programs, including Medicaid. ..."

For two full years, the State has collected data from the three Institution for Mental Disease (IMD) facilities on the average response time by the service providers. DSAMH has contracts with each IMD to pay for clients who do not have insurance. As part of the contract, the IMD is required to have its doctors reach out to the client's doctor to discuss patient care and discharge planning. Recently, because of the revisions in the Managed Care Organization contracts, the State now can track the response time for all state-funded clients in the IMDs, including clients funded by Medicaid.

The Settlement Agreement requires that the service providers respond within 24 hours form the time of admission.

The graph below shows the average response time for a two-year period per IMD:

## Average Provider Response Time To Hospitalization FY15



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
<b>Dover</b>	2.00	4.43	3.83	1.50	1.50	3.75	0.67	1.25	1.00	1.88	2.50	2.33
<b>MeadowWood</b>	2.69	3.35	3.67	1.00	1.40	1.00	1.00	0.88	1.07	0.96	0.93	1.00
<b>Rockford</b>	1.14	4.43	1.80	1.88	1.25	1.50	1.00	1.67	1.00	0.80	0.33	1.00
<b>Total</b>	1.94	4.07	3.10	1.46	1.38	2.08	0.89	1.26	1.02	1.21	1.25	1.44

The State now has information from both the service provider and the IMD that can assist when the State chooses to drill down to see the average response time of a particular service provider and then a particular team. This information is an excellent management tool and is being used, along with other data, to assist the teams in better service delivery.

### Fourth Report: September 24, 2013

*Crisis Walk-In Centers – Recommendation: Page 17 line 498:*

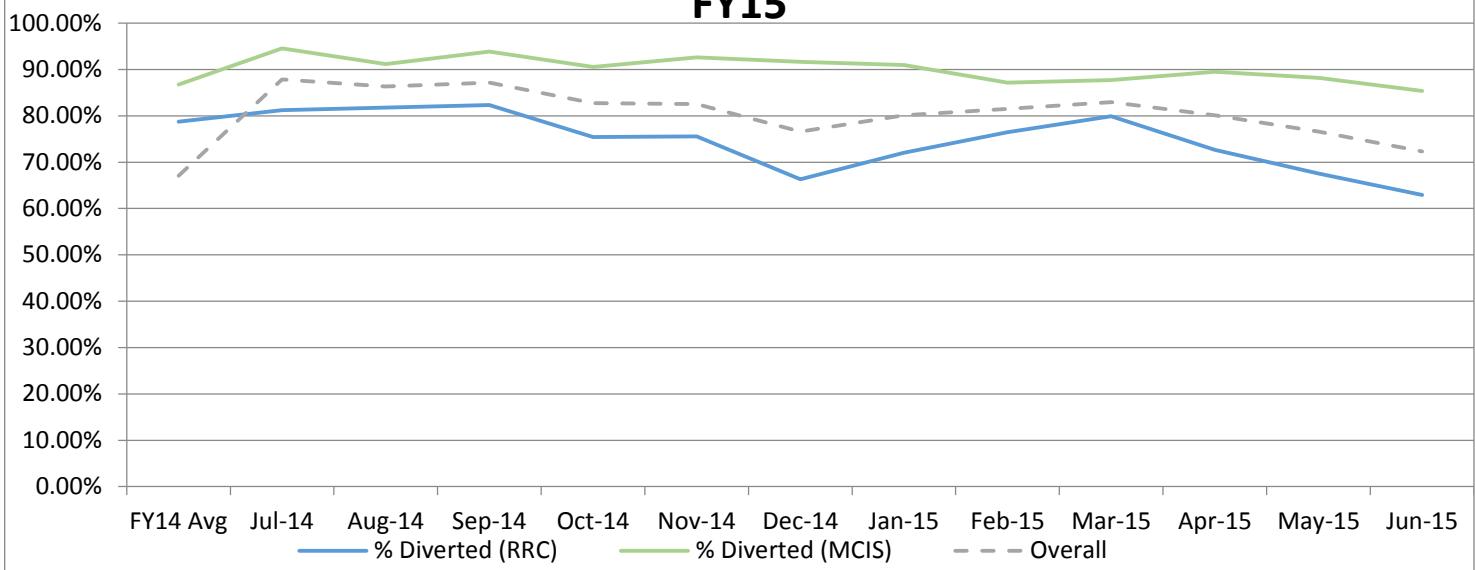
“... the State should examine whether the capacities of the RRC reflect the needs of the southern part of Delaware in order to assure there is ready access to the services ... and there is not a back-up in the E.D. in Kent and Sussex Counties.”

“... the State should evaluate an expansion of the RRC to include overnight crisis services.”

“... the State should consider developing a RRC model Crisis Walk-In Services in NCC.”

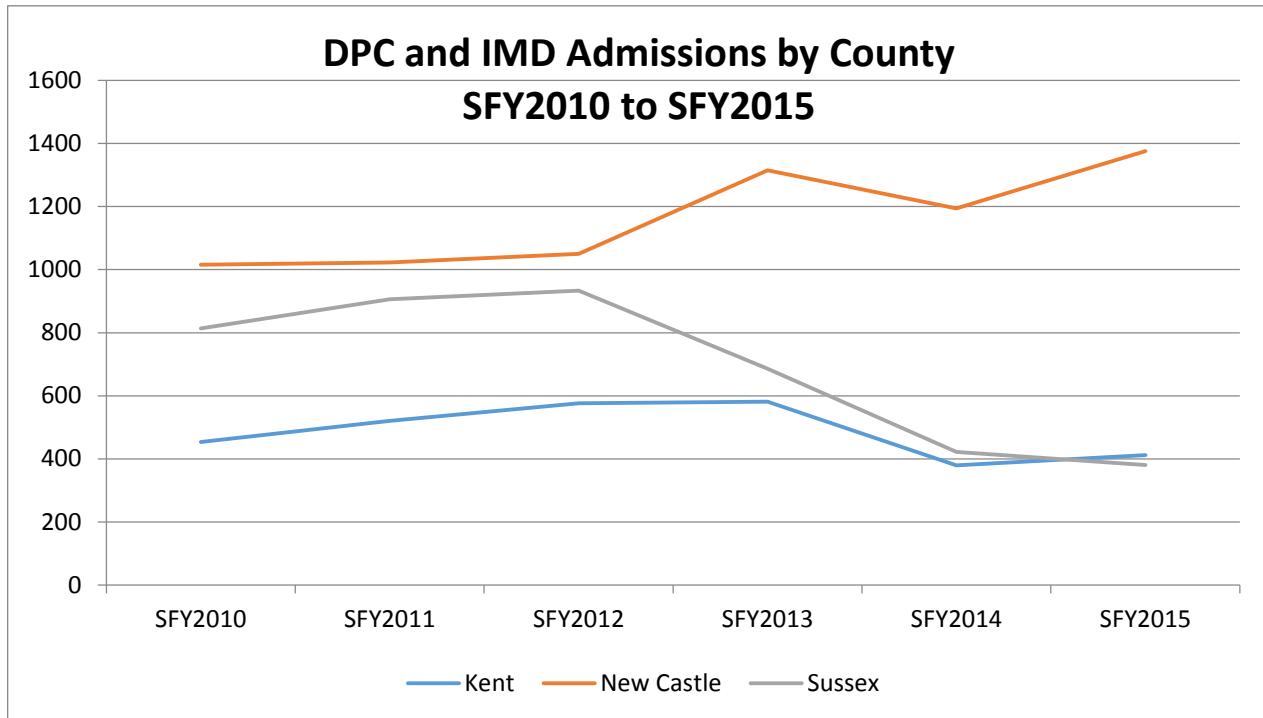
Over the past two years, the State has had major success in the Resource Recovery Center (RRC) in Ellendale. The chart below indicates the success rate of diversion by the RRC from a 5- to 7-day stay in a hospital. Individuals who are seen at the RRC are not precluded from being referred to a hospital by RRC staff. Similarly, individuals who need crisis stabilization and succeed in regaining equilibrium within the 23-hour stay at the RRC are not required to experience hospitalization. The RRC and a psychiatric hospital both have roles to play when the client is in need.

## RRC and MCIS Hospital Diversion Rate FY15



The State has seen such success with the Recovery Response Center (RRC) in Ellendale that it is in the process of opening up a 16-bed facility in New Castle County.

As an additional point of information to the success of the RRC, the following graph represents the number of individuals sent to a hospital (Rockford, MW and BH, plus DPC). This does not include the Wilmington hospital, as it does not accept individuals under an involuntary detention order. Interestingly, the crisis center in Ellendale opened in FY12. Look at the gray line from that point onward. In addition, while initially that program focused on Sussex County, in subsequent years it began taking more clients from Kent General. In fact, more clients are now sent from Kent County to the RRC in Sussex, than within Sussex County itself. The blue line shows a similar trend. As of the time of this report, the State is preparing to open another crisis center in New Castle County – most likely in June 2016 – and anticipates a similar trend in this county. For every hospitalization that is diverted – and that is one of the strengths of these programs – a bed is freed up for another individual.



IMD and DPC Admissions SFY2010 to SFY2015	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
Kent	453	520	576	581	379	412
New Castle	1016	1023	1050	1315	1194	1376
Sussex	814	906	933	686	422	380
Total	2283	2449	2559	2582	1995	2168

#### Fifth Report: May 19, 2014

*Crisis Stabilization Services – Reduction in Inpatient Bed Days – Recommendation: Page 25 line 755:*  
 “As the State Plan to reduce Inpatient Bed Days goes into effect, it is critical that the State has unified data to allow for meaningful UR, ongoing program and refinement and to demonstrate the measures on the impact on bed use. ... this information helps demonstrate the State is making its best efforts to achieve compliance.”

In the Third Annual Progress Report, the State wrote extensively about the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program. 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. The goal of PROMISE is to provide community supports to facilitate enhanced engagement within the community for persons with serious and persistent mental illness while leveraging federal dollars with state dollars for those eligible for Medicaid.

## **Sixth Report: December 29, 2014**

*Crisis Walk-In Centers Recommendation: Page 15 line 366:*

“ ... the State develop “dashboard” measures to track the use of Crisis Walk in Centers to assess people who are under 24-hour psychiatric detention to determine if additional services are needed.”

The crisis walk-in center provides an opportunity for a client to be stabilized and assessed to determine if the client needs additional treatment in a hospital setting. The State has developed “dashboard” items that detail monthly the number of people who go to a crisis walk-in center and from that group how many are then admitted to a psychiatric hospital, discharged to the community, or admitted to the walk-in center voluntarily or involuntarily.

### ***CIVIL COMMITMENT:***

In his Second and Third Report, the Court Monitor focused on the use of civil commitments and the number of people who were committed both inpatient and outpatient. The Settlement Agreement contains no benchmarks regarding civil commitment, however, recognizing its role in the mental health system, the State engaged in a vigorous reform process involving numerous stakeholders. As a result, Delaware has transformed its civil commitment process. See the Second and Third Annual Progress Report by the State for a full explanation of the revisions to the commitment laws.

Below are two recommendations made by the Court Monitor in the Second and Third Report regarding civil commitment:

### **Second Report: September 5, 2012**

*System Reconfiguration – Civil Commitment – Recommendation: Page 6 line 196:*

“ .... The Monitor recommends the State track changes in the following measures:

Involuntary Hospitalizations

Voluntary Hospitalizations

Outpatient Commitment Orders

“ ... The Monitor recommended that the State revise its required document for court-ordered treatment so that it includes clear information as to why less-restrictive measures are not seen as viable ... ”

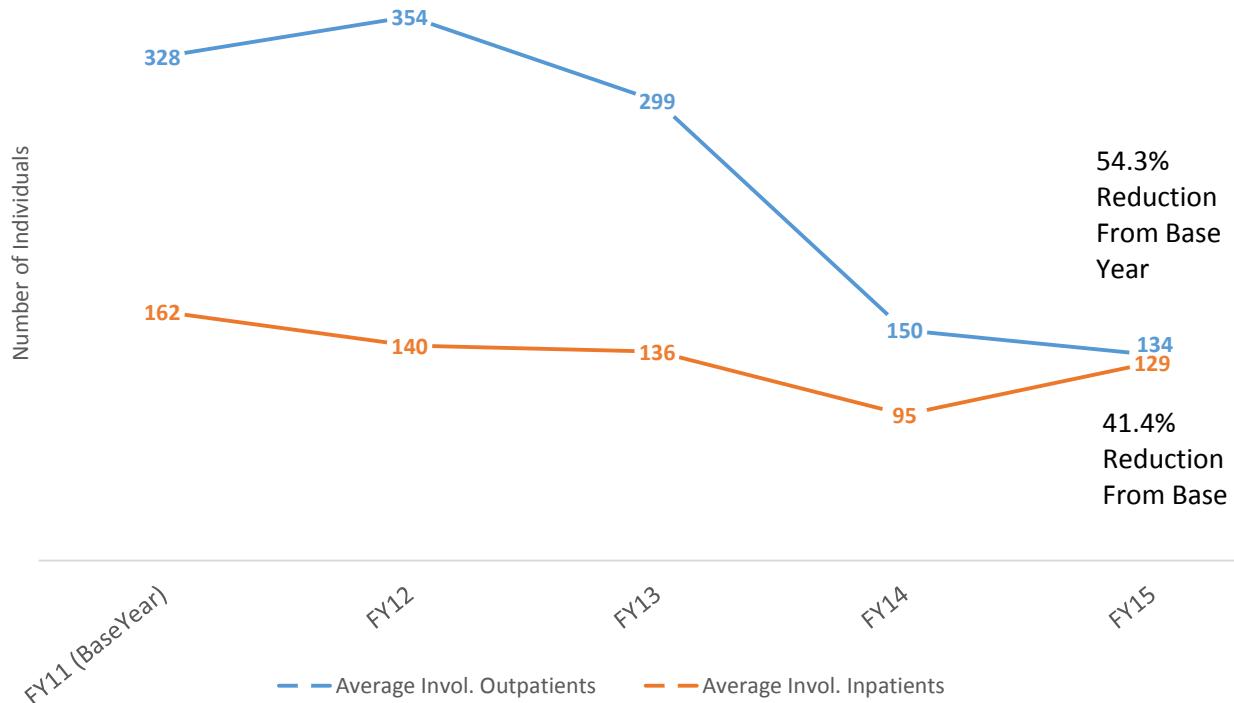
### **Third Report: March 8, 2013**

*Civil Commitment – Recommendation: Page 9 line 319:*

“Production of monthly trending relating to voluntary, involuntary hospitalization and outpatient commitment. ... Inform individuals of their rights when subject to court-ordered commitment ... consistent system-wide practice that encourages voluntary treatment and promotes healthcare advanced directive for individuals to determine their care instead of the courts.”

Before the Settlement Agreement was signed, the State has been monitoring the number of commitments per year. Below is a graph of the status of voluntary and involuntary commitments since FY11. Since the Settlement Agreement was implemented in FY11, inpatient civil commitments have been reduced by 41 percent and outpatient civil commitments have been reduced by 54 percent. This remarkable and significant reduction is due not only to the changes made to the civil commitment law, but also to the increased availability of community-based services to allow the State to better serve people in the community without relying on inpatient treatment.

## INVOLUNTARY INPATIENT /OUTPATIENT BY FISCAL YEAR



\*This data is based on information provided to the Eligibility and Enrollment Unit (EEU) during commitment hearings

### Involuntary Commitments

Type	FY11 (Base Year)	FY12	FY13	FY14	FY15
Average Invol. Outpatients	328	354	299	150	134
Average Invol. Inpatients	162	140	136	95	129

### SECTION III: STATE COMMITMENT TO FUNDING SUSTAINABLE MENTAL HEALTH SERVICES

Broadly, the Olmstead Decision is about serving client in the least restrictive environment with community-based services appropriate for that individual's needs and based on their expressed preferences. "There should be due consideration given to (1) whether such community-based services are appropriate, (2) the individuals being provided such services do not oppose community-based treatment, and (3) the resources available to the State and the needs of other persons with disabilities. *Olmstead v. L.C.*, 527 U.S. 581 at 607 (1999) (also cited in Section III Implementation Timeline I Supportive Housing para 6 page 13 of the Settlement Agreement). For many decades, the majority intensive services for persons with SPMI were in an institutional setting. There were community services, but as a general rule people with the most severe disability were served in an institutional setting.

The Settlement Agreement with the State of Delaware redirected the funding and services from institutions to community-based services with an emphasis on providing services that treated a wide range of clients with disabilities.

Treatment is never “one size fits all.” The Supreme Court in Olmstead did not mandate community treatment if such treatment is not appropriate for a given individual. Delaware recognizes the value of individualized service delivery and a variety of levels of care to support the target population. Some individuals may need more intensive treatment, such as visits to a psychiatric hospital, some need to be in a hospital for a duration longer than 14 days, some may need the constant supervision afforded via a group home model and others can live independently receiving community-based services. Also, individual need may change over time based on the stability of the mental illness and the treatment plan should allow for re-assessments to promote the right level of care and supervision.

In recognition of the variety of ways that people need mental health services, Delaware has sought to diversify its service options as well as strengthen and expand its community-based services so that inpatient treatment is not the only option for persons with a higher level of need.

The following are a few examples of how the State of Delaware has redirected financial resources and developed a sustainable mental health system of community-based services:

**1. Examples of Sustainable Housing Options:**

- a. **Section 811 Demonstration Program (811):** The 811 program is a federally funded rent subsidy program (U.S. Department of Housing and Urban Development) that is specifically for clients with a disability and who are affected by a state settlement agreement or being deinstitutionalized and receiving community-based services. This is an independent living housing option.
- b. **State Rental Assistance Program (SRAP):** SRAP is a state-funded housing voucher program that is statewide. The client pays 28% of his/her income toward the rent of an apartment/house or mobile home and the state provides a monthly subsidy for the balance of the rent (the rent must meet fair market standards as developed by the State). This is an independent living housing option.
- c. **Supervised Apartment Program (SAP):** The Supervised Apartment Program, funded by the state through the DSAMH base budget, provides a stepping-stone for clients who are discharged from DPC and who need a housing option that has supportive services, but is not in an institutional setting. The clients who choose SAP typically are receiving services from an ACT Team. The supervision offered by SAP is in the nature of checking in on the client and if the client needs assistance, contacting the ACT Team. This is a semi-independent housing option.

**2. Examples of Sustainable Partnership with sister State Agencies:**

- a. **Delaware State Housing Authority (DSHA):** The Department of Health and Social Services (DHSS), the Department of Services for Children, Youth and Their Families, and DSHA entered into a partnership to create the State Rental Assistance Program (SRAP). This housing voucher program has provided subsidies for DSAMH clients to live independently in the community.

Additionally, DSHA and DHSS entered into another partnership to submit a proposal to the U.S. Department of Housing and Urban Development (HUD) to provide 150 project-based housing

subsidies through the State through the Section 811 demonstration Program. DSHA was awarded the 20-year grant providing housing resources to all DHSS clients who meet the priority criteria, which includes persons at risk of institutionalization or currently in an institution. The Section 811 Demonstration Program is a resource for clients with SPMI to find and secure housing on a long-term basis.

- b. Division of Medicaid and Medical Assistance (DMMA): DMMA and DSAMH – both divisions of DHSS – enhanced their partnership to develop a comprehensive Medicaid waiver that would allow the state to leverage federal funding (Medicaid dollars) with state funding. The enhanced Medicaid benefit package, coordinated by DSAMH through the fee-for-service program, complies with home and community-based standards and assurances that the services meet the standards of the signed Olmstead agreement. The resulting program is Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), which 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 for persons with serious and persistent mental illness.
- c. Department of Labor (DOL): DSAMH has worked closely for years with DOL and the Division of Vocational Rehabilitation to provide training and employment services to clients with SPMI.

### 3. Examples of Sustainable Partnership with Federal Government:

- a. U.S. Department of Housing and Urban Development (USHUD): HUD updated its Section 811 housing program to meet the needs of clients with disabilities who are being deinstitutionalized throughout the country because of the Olmstead decision and Settlement Agreements between individual states and the U.S. Department of Justice (DOJ). The State of Delaware, through a partnership between DSHA and DHSS, submitted a proposal to HUD for 150 Section 811 units. The proposal was approved by HUD, and the State was awarded a grant for 140 units for up to 20 years.
- b. Center for Medicare and Medicaid Services (CMS): CMS is a federal agency that among other things provides Medicaid funding to states so they can implement their Medicaid programs. Delaware has leveraged the state funding for mental health services by submitting a waiver to CMS. The approval of the waiver allows additional funding for supplementing health and home-based services to clients with SPMI. Such supportive services include care management, respite, personal care, non-medical transportation, nursing, peer supports, and other individualized supports.

In general, state and federal dollars funds community-based services. The grant from HUD, with the matching funds from Medicaid through CMS, have reduced the cost to the state and ensured that federal dollars will be a long-term funding source for sustainability.

## **SECTION IV: UNIVERSITY OF PENNSYLVANIA EVALUATION OF COMMUNITY MENTAL HEALTH SERVICES**

DSAMH contracted with the University of Pennsylvania (UPenn) Center for Mental Health Policy and Services Department of Psychiatry to conduct assessments and analysis on the Community Re-Integration Services Program (CRISP), the Assertive Community Treatment (ACT) Teams and the Intensive Care Management (ICM) Teams.

UPenn has been working with DHSS for years on data analysis. University researchers understand the data collected by DSAMH and its service providers, including Medicaid data, which always has been an integral part of funding services for persons with serious and persistent mental illness.

Through its collaboration with UPenn, the State has been producing data necessary to meet some of the targets of the Settlement Agreement (as identified below), but also to inform and grow its own service performance measurements and review.

In the Settlement Agreement - Section V. Quality Assurance and Performance Improvement it states: "The goal of the State's Quality Assurance and Performance Improvement System shall be to ensure that all mental health services funded by the State are of good quality and sufficient to help individuals achieve positive outcomes, including increased integration and independence and self-determination in all life domains...."

The Settlement Agreement goes on to say in Section V. Paragraph D. Quality Service Reviews: "The State will use Quality Service Reviews (QSRs) to evaluate the quality of services at an individual, provider and system-wide level. QSR's collect information through a sample of face-to-face interviews of the consumer, relevant professional staff and other people involved in the consumer's life, and through review of individual treatment plans."



UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM  
Center for Mental Health Policy and Services  
Department of Psychiatry

## Summary of CRISP & QPR Update 2015

*Evaluation of the Delaware Division of Substance Abuse and Mental Health (DSAMH) Department of Justice (DOJ) strategic initiative effects to enhance community integration of individuals with substance abuse and mental health disorders.*

**Submitted by:** Cynthia Zubritsky PhD & Bridget Keogh  
Center for Mental Health Policy and Services Research  
Department of Psychiatry, University of Pennsylvania

### CRISP EVALUATION

**Institutional Review Board (IRB)** This evaluation has been approved by the University of Pennsylvania (UPenn) IRB and the Delaware Department of Health and Social Services (DHSS) IRB.

**Primary Aim** The primary aim of this study is to investigate what changes occur for individuals with SPMI in key outcome domains of: 1) quality of life; 2) symptom severity; 3) satisfaction with services; 3) level of functioning; and 4) attitudes toward community living, between discharge from DPC into a community living arrangement (CRISP), at baseline and annual follow-up over five years.

**Target Population** The target population includes approximately 100 individuals who are designated as members of the CRISP target population, who are transitioning into community living arrangements from DPC as a result of the DOJ Settlement Agreement. Individuals living in the community who are designated as appropriate for CRISP placement will be added to the CRISP target population and analyzed both within the CRISP cohort and as a separate cohort.

**Methods** Individuals in the target population will be assessed by using standardized assessment instruments delivered by a trained DSAMH peer at baseline and annually thereafter for five years.

**Consent** Prior to August 2014, written consent was required for CRISP participants to be interviewed. After August 2014, oral consent has been approved for the CRISP interview. A witness – anyone available at the provider the day that the consent is completed, including another consumer – is required to be present during the consent process and sign the oral consent form under “Witness 1.” Two witnesses are preferable, but not required. If a second witness is available, the second person will sign under “Witness 2.”

Consumers are asked for their language of choice for the CRISP interview. If a language other than English is requested, the CRISP interviewer will work with the provider to access a translator.

**CRISP Interview** The CRISP interview is offered to every CRISP client after discharge from the hospital (baseline) and is administered on the anniversary of the baseline CRISP interview annually for five years. Two DSAMH consumer interviewers were identified and trained to conduct the CRISP interview. The CRISP interview is derived from SAMHSA’s National Outcome Measures (NOMs) and includes questions related to physical health, mental health, substance use, trauma, perception of care, social connectedness, housing and criminal justice status. DSAMH Executive Staff, the Office of Consumer Affairs and Delaware consumers were involved in the development of the CRISP interview and selection of all CRISP measures.

The CRISP consumer interviewers, Ms. McCole and Mr. Topal, were recommended by the Office of Consumer Affairs and are experienced interviewers who have conducted DSAMH consumer satisfaction surveys over the past five years. Several meetings with the University of Pennsylvania (UPenn), the Office of Consumer Affairs and the consumer interviewers occurred to review the instrument and practice delivering the CRISP interview. In addition to preliminary training, each interviewer’s first interviews were conducted under the supervision of DSAMH’s Director of Consumer Affairs.

The CRISP consumer interviewers have completed the CITI Protection of Human Subjects Research training, a requirement of all UPenn researchers. That online training has an extensive curriculum designed to provide researchers with a foundation of basic social and behavioral research principles. The curriculum includes modules on: Belmont Report, History and Ethical Principles, Defining Research with Human Subjects, the Regulations and the Social and Behavioral Sciences, Informed Consent, Privacy and Confidentiality, Research with Prisoners, Research with Children, Research in Public Elementary and Secondary Schools, International Research, Internet Research, Research and HIPPA Privacy Protections, Vulnerable Subjects and Conflicts of Interest.

The CRISP cohort is determined by DSAMH’s Eligibility and Enrollment Unit (EEU). The EEU Director provides the Office of Consumer Affairs with an updated list of CRISP clients. The Office of Consumer Affairs works with

UPenn to schedule interviews with the CRISP clients. The location of the interviews depends on the status of the CRISP client and varies for each client based on his/her schedule. For example, if a client lives in supported housing, but attends a day program at his/her provider agency in the community, the interview will be conducted at the provider agency if preferred.

If a CRISP client refuses the CRISP interview, the refusal is documented and submitted to the Office of Consumer Affairs. Once a CRISP client has refused an interview three times, the evaluation team suspends contact with the client for six months. After six months, the CRISP client is reengaged and asked to complete the CRISP interview.

The CRISP consumer interviewers provide important feedback to project staff as well as an empathetic interaction when engaging CRISP clients. The CRISP interviewers introduce themselves to the CRISP clients and explain that they have lived experience. The CRISP interviewers also advise the interviewee that the interview can be stopped at any time for questions or if the interviewee is uncomfortable. Each CRISP interviewer has a business card with the interviewer's name and contact information for the Consumer Affairs office which is distributed to each CRISP client.

Upon interview completion, the Peer Specialist interviewer, seals the CRISP Interview in a 10 x 13-inch opaque envelope. The Peer Specialist delivers the completed CRISP Interviews, secured individually in sealed envelopes, to the Office of Consumer Affairs at the Division of Substance Abuse and Mental Health (DSAMH). The Director of the Office of Consumer Affairs, Penny Chelucci, enters the CRISP Interview data into a secured database within 48 hours of receiving an interview. Prior to and after the DSAMH data has been entered, the CRISP Interviews are stored in a locked filing cabinet in the DSAMH Director's office. The Director of DSAMH and the Executive Assistant to the Director are the only personnel with access to the locked filing cabinet.



**Status of Interviews** The third year of CRISP interviews is in progress and scheduled to be completed by the end of October 2015. As of July 27, 2015, 70 consumers completed the CRISP interview, seven consumers refused the interview and 15 consumers remain to be interviewed.

**Anticipated Analyses** The University of Pennsylvania evaluation team will conduct trend analyses to identify significant changes in the CRISP cohort over time. The evaluation team also will employ a correlation analysis of health and social connectedness to explore any existing relationship between these domains.

### **QUALITY PROCESS REVIEW (QPR) EVALUATION**

**Primary Aim** In response to Delaware's Settlement Agreement with the Department of Justice, the QPR was created in September 2013. Section V.D. of the Settlement Agreement calls for Delaware to utilize the Quality Services Review (QSR) "to evaluate the level of quality of services at an individual, provider and system-wide level." The State received approval from the DOJ to develop its own quality assurance process (QPR) that addresses ACT and ICM services in Delaware. The primary aims of Delaware's QPR are to measure outcomes in

Delaware's ACT and ICM programs; guide behavioral health system leaders in evaluating their programs in a rigorous and systematic manner; and, ensure consumer input into service quality.

**Target Population** The target population comprises 16 percent of individuals who are receiving ACT and ICM services in Delaware.

**Methods** Among Delaware's ACT and ICM programs, 16 percent of the individuals are randomly chosen by MCI number and interviewed annually by trained QPR interviewers. The QPR team also conducts chart reviews for each consumer interviewed. The study design is a longitudinal assessment of consumer-reported outcomes including physical health, quality of life, relationships, goal planning, employment, access to services, housing, natural and peer supports and social connectedness.

**Status of Interviews** The 12-month QPR reassessment data are being entered into the secure QPR database. As part of the baseline and 12-month reassessment, 245 consumers were interviewed.

**Anticipated Analyses** Penn has conducted frequency analyses to describe consumer's experiences in ACT and ICM programs. The DSAMH QPR has presented baseline findings to each provider and will be presenting reassessment findings later this year. Critical questions have been identified and the Penn evaluation team will perform a trend analysis focusing on these critical questions to identify changes over time.

## **APPENDIX I – STATUS OF THE SETTLEMENT AGREEMENT TARGETS AS OF JUNE 2015 (EIGHTH REPORT OF THE COURT MONITOR)**

Under the Settlement Agreement, the Court Monitor is required to issue a report every six months. The Eighth Report was issued December 26, 2015, six months after FY15 ended.

The targets in this Annual Report represent all the targets listed in the Settlement Agreement. They are listed by target, which have met substantial compliance and which have not. The chart below, developed by the Court Monitor, details compliance and non-compliance.

### **STATUS OF THE SETTLEMENT AGREEMENT TARGETS FOR FY15**

**Summary of Compliance Ratings for FY15\***

<b>Factor</b>	<b>Reference in the Agreement</b>	<b>Compliance Rating</b>
Crisis Hotline	III.A	Substantial Compliance
Mobile Crisis Services	III.B.1	Substantial Compliance
Crisis Walk-In Centers	III.C	Substantial Compliance
Crisis Stabilization Services	III.D.3-4	Partial Compliance
Crisis Diversion Training	III.A.2, III.B.2, III.C.2, III.D.2	Substantial Compliance
Crisis Apartments	III.E	Substantial Compliance
Assertive Community Treatment	III.F	Substantial Compliance
Intensive Case Management	II.D.2.b, III.G.1-2	Substantial Compliance
Case Management	II.D.2.c.ii, III.H	Substantial Compliance
Supported Housing	III.I.5	Substantial Compliance
Supported Employment	III.J.1-4	Substantial Compliance
Rehabilitation Services	III.K.4	Substantial Compliance
Family & Peer Supports	III.L.1-4	Substantial Compliance
Discharge Planning	III.C.2.d.iii-iv	Partial Compliance
Quality Assurance	V.A	Partial Compliance
Risk Management	V.B.1-10	Partial Compliance

\*Page 3: Eighth Report Court Monitor – December 26, 2015

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 describes the Target Population and the areas of community-based services that must be enhanced. Within each area are targets with specific goals. Each goal has benchmarks to be achieved over the five-year 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 Four (FY15) of the Settlement Agreement. The Court Monitor rated all the targets in the Eighth Report (see the table below).

#### ***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:*** Staff who 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:*** They 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:*** Place 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:

#### ***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***
- There are no Targets for FY15: 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***

The State has met its targets and continues to maintain a 24/7 crisis hotline. It is 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 (FY12): 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 that 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***
- There are no Targets for FY15: 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***

#### ***Crisis Walk-in Centers – Targets by Fiscal Year***

- By September 1, 2012 (FY13) 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 (FY13): 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 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***
- There are no Targets for FY15: 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***

#### ***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***
- By July 1, 2015 (FY15): There are no targets for FY15 although the target for FY14 was in Partial Compliance (reduction of bed days by 30 percent) and has remained so throughout FY15. ***Partial Compliance***

#### ***Crisis Diversion Training – (III. A.2., III.B.2., III.C.2., III.D.2.)***

- Section III.A.2. By July 1, 2012 the State will provide public materials and training about crisis hotline services in every hospital, police department .... ***Substantial Compliance***
- Section III.B.2. By July 2013 the state will train all state and local law enforcement personnel about the availability and purpose of the mobile crisis teams ... ***Substantial Compliance***
- Section III.C.2. By July 2013 the state will train all state and local law enforcement personnel about the availability and purpose of the crisis walk-in centers ... ***Substantial Compliance***
- Section III.D.2. By July 2013 will train all provider staff and law enforcement personnel to bring people experiencing a mental health crisis to walk in centers for assessment .... ***Substantial Compliance***

#### ***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***

#### ***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 four apartments are spread throughout the State. ***Substantial Compliance***
- There are no Targets for FY14: The State expanded its crisis apartment beds from two beds in New Castle County and two beds for Kent and Sussex Counties to four beds for New Castle County and four beds for Kent and Sussex Counties. ***Substantial Compliance***
- There are no Targets for FY15: The State expanded its crisis apartment beds from two beds in New Castle County and two beds for Kent and Sussex Counties to four beds for New Castle County and four beds for Kent and Sussex Counties. ***Substantial Compliance***

#### ***Assertive Community Treatment – Targets by Fiscal Year***

- By July 1, 2012 (FY13): The State will expand its eight 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 nine. ***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***
- By September 1, 2015 (FY15): The State will add an additional ACT team that is in fidelity with the Dartmouth model for a total of 11. ***Substantial Compliance***

### ***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 by one team. In FY14, the State consulted with the Court Monitor to convert four of the five ICM teams to ACT Teams. ***Substantial Compliance***
- There are no targets for FY15: The State had five ICM teams in FY14, exceeding the target by one team. In FY15, 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 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. In FY15, the four ICM teams (three in New Castle and one in Kent) were converted. The ICM Team in Sussex County would remain an ICM Team. The State also reserved the right to decide that if clients progressed and did not require the number of services offered by the ACT Teams, officials may rethink the use of ICM Teams and reopen an ICM Team in New Castle County.

### ***Case Management- Targets by Fiscal Year***

- By July 1, 2012 (FY12): 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***
- By September 1, 2015 (FY16): The State will train and begin to utilize three additional case managers for a total of 25 case managers. ***Substantial Compliance***

The State has met the Target for FY15. Targeted Case Managers are staffed in the State system, as well as offered by Recovery Innovations on a contract basis. The State TCM provides a high level of care and is typically an interim service until the client is transitioned onto an ACT Team. The TCM services provider by RI are either to assist in stabilizing a client as he or she transitions from provided services to integration in the community without services, or as he or she waits to be transitioned onto an ACT team. The State TCM program has transitional housing for clients, while the TCM program with RI assists the client to find housing. There were 25 case managers as of June 30, 2015.

### ***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***
- By July 1, 2015 (FY15): The State will provide housing vouchers or subsidies and bridge funding to a total of 650 individuals. ***Substantial Compliance***

The State has met its Target for FY15 of 100 integrated units.

Year Four (FY15) 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.

#### ***Supported Employment – Targets by Fiscal Year***

- By July 1, 2012 (FY12): The State will provide supported employment to 100 individuals per year. ***Substantial Compliance***
- By July 1, 2013 (FY13): The State will provide supported employment to 300 additional individuals per year. ***Substantial Compliance***
- By July 1, 2014 (FY14): The State will provide supported employment to 300 additional individuals per year. ***Substantial Compliance***
- By July 1, 2015 (FY15): The State will provide supported employment to 400 additional individuals per year. ***Substantial Compliance***

“Section III.J.2 of the Agreement requires the state to provide supported employment services to an additional 400 individuals.” DSAMH continues to have a strong partnership with the state Department of Labor’s Division of Vocational Rehabilitation, which puts a priority on individuals with SPMI entering the workforce. As of the end of FY15, 729 individuals were being served.

See the discussion on Supported Employment in Section II: Status of Court Monitor recommendations of this report.

#### **Rehabilitation Services**

- By July 1, 2012, the State will provide rehabilitation services to 100 individuals per year. ***Substantial Compliance***
- By July 1, 2013, the State will provide rehabilitation services to 500 additional individuals per year. ***Substantial Compliance***
- By July 1, 2014, the State will provide rehabilitation services to 500 additional individuals per year. ***Substantial Compliance***
- By July 1, 2015, there were no targets for FY15. ***Substantial Compliance***

“Section III.K.2 of the Agreement requires the State to provide rehabilitation services to an additional 500 individuals by July 1, 2014, bringing the total requirement to 1,100. Rehabilitation services comprise an array of activities, such as education, substance abuse treatment, and recreational activities.”

## **Family and Peer Supports**

- By July 1, 2012, the State will provide family or peer supports to 250 individuals per year. ***Substantial Compliance***
- By July 1, 2013, the State will provide family or peer supports to 250 additional individuals per year. ***Substantial Compliance***
- By July 1, 2014, the State will provide family or peer supports to 250 additional individuals per year. ***Substantial Compliance***
- By July 1, 2015, 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 1,000. 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 FY15.”

## **Quality Assurance and Performance Improvement:**

Section V.A. of the Agreement states “The Goal of the State’s Quality Assurance and Performance Improvement System shall be to ensure that all the mental health services funded by the state are of good quality and sufficient to help individuals achieve positive outcomes including increased integration into the community ....”

Although the State is conducting many QA/PI activities, those activities have not been incorporated into a system-wide approach. As noted in the Eighth Report, QA/PI activities have not been integrated into a comprehensive approach to monitoring quality and implementing performance improvement. ***Partial Compliance***

## **Risk Management:**

Section V.B.1-10 Risk Management is a system-wide initiative that evaluates the harm to a client and the process by which the harm is investigated and remediation is implemented to prevent future incidents. ***Partial Compliance***

## **APPENDIX II – RECOMMENDATIONS FROM THE COURT MONITOR – IN EIGHT SIX-MONTH REPORTS**

### **Eighth Report December 26, 2015 (No Recommendations)**

### **Seventh Report June 11, 2015 (Two Separate Sets of Recommendations)**

*Referrals for Specialized Mental Health Services and Supported Housing - Recommendation: Page 9 line 239:*

“The States list of individuals whose care is managed through the MCOs and who are considered to be at an elevated risk of hospitalization or other adverse outcomes has not been updated since June 2014. ... it is recommended that the State update this list...”

*Supported Employment - Recommendation: Page 13 line 373:*

“ ... While the job market remains competitive, the State has indicated it could likely achieve even further improvements if additional trained employment specialists were available to work with the targeted population and prospective employers. ... While the State is in Substantial Compliance with supportive employment ... it is an outcome that goes to the core of the Settlement Agreement intent. ... It is recommended that the State consider an expansion in the number of trained employment specialists working with the target population.”

### **Sixth Report December 29, 2014 (Three Separate Sets of Recommendations)**

*Crisis Walk-In Centers – Recommendation: Page 15 line 366:*

“ ... the State develop “dashboard” measures to track the use of Crisis Walk-In Centers to assess people who are under 24-hour psychiatric detention to determine if additional services are needed.”

*Delaware’s Plan to Reduce Bed Days – Recommendation: Page 22 line 568:*

“... that the State have unified data systems to ensure that the strategies implemented to reduce bed days are effective.”

*Supported Employment – Recommendation: Page 38 line 871:*

“It is recommended that the State focus intensely on securing employment for the substantial population of individuals who are categorized as “Ready to Work.”

### **Fifth Report: May 19, 2014 (Four Separate Sets of Recommendations)**

*Use of Data – Recommendation: Page 7 line 231:*

“It is strongly recommended that the State redouble its efforts to make immediate improvements in its data capacities, particularly with respect to individuals with SPMI whose care is managed by DMMA. It is

essential that the State has timely and accurate information about the numbers of individuals with SPMI who are service through public programs. ...”

*Crisis Stabilization Services – Reduction in Inpatient Bed Days – Recommendation: Page 25 line 755:*

“As the State Plan to reduce Inpatient Bed Days goes into effect, it is critical that the State has unified data to allow for meaningful UR, ongoing program and refinement and to demonstrate the measures on the impact on bed use. ... This information ... helps demonstrate the State is making its best efforts to achieve compliance.”

*Crisis Stabilization Services – Discharge Planning – Recommendation: Page 26/27 line 801:*

“Engagement of a community provider in discharge planning for hospitalized individuals” ... compliance with this provision must be for all individuals who receive State-funded services and have SPMI ...

“State to establish a consistent system-wide process documenting community involvement  
Include monitoring compliance on the State dashboard.”

*Risk Management – Recommendation: Page 40 line 1124:*

“... that DHSS establish a unified, system-wide process for reporting adverse events, conducting investigations and root causes analyses, ensuring corrective actions and broadly implementing preventative measures. ”

**Fourth Report: September 24, 2013 (Six Separate Sets of Recommendations)**

*Use of Data – Recommendation: Page 8 line 238:*

“DSAMH has improved its data collection and data-driven oversight of services ... DSAMH remains significantly limited in its ability to produce and appropriately analyze data in ways it will maximize its performance. ...”

*Management of Clinical Services – Inpatient Care Management by DMMA – Recommendation: Page 13 line 401:*

“... ensure that clients who are funded by Medicaid for inpatient hospital stays and who meet the definition of SPMI by diagnosis are allowed the deep-end services provided by DSAMH and that the State develop a long-range management strategy for services. ...”

*Crisis Walk-In Centers – Recommendation: Page 17 line 498:*

“... the State should examine whether the capacities of the RRC reflect the needs of the southern part of Delaware in order to assure there is ready access to the services ... and there is not a back-up in the E.D. in Kent and Sussex Counties.”

“... the State should evaluate an expansion of the RRC to include overnight crisis services.”

“... the State should consider developing a RRC model Crisis Walk-In Services in NCC.”

*Assertive Community Treatment – Recommendation: Page 23 line 670:*

“... the Court Monitor has recommended that the State further expand the number of ACT teams by two (from 11 to 14) ... (forensic and co-occurring mental illness and substance abuse) ...”

*Supported Employment – Recommendation: Page 27 line 805:*

“.... the redesign for ACT to TMACT as complete and with the redesign it was recommended by the Court Monitor to dedicate one position within the TMACT positions to supported employment ...”

### **Third Report: March 8, 2013 (Six Separate Sets of Recommendations)**

*Data Systems – Recommendation: Page 3 line 99:*

“... today’s information technology has not been meaningfully embedded. ... It is very important that DSAMH have the analytic expertise to integrate both information and service delivery elements. The recommendation to bring the staffing capacity to DSAMH to allow for such analytic expertise...”

*Target Population List – Recommendation: Page 6 line 189:*

“DSAMH has plans to use DELJIS arrest information to alert providers so they can intervene on behalf of the individuals. ... Every arrest of a person on the target population list should trigger a root cause analysis to inform service refinements on individuals and aggregate levels. ....”

*Civil Commitment – Recommendation: Page 9 line 319:*

“... production of monthly trending relating to voluntary, involuntary hospitalization and outpatient commitment. ... Inform individuals of their rights when subject to court-ordered commitment ... consistent system-wide practice that encourages voluntary treatment and promotes healthcare advanced directives for individuals to determine their care instead of the courts.”

*Inpatient Psychiatric Care – Recommendation: Page 11 line 386:*

“... it is strongly recommended that the State establish a single – and unshifting – point of accountability for oversight, monitoring, and maintenance of information relating to psychiatric hospitalizations on individuals and aggregate levels. ...”

*Transition Planning – Recommendation: Page 13 line 452:*

“The State should move quickly to ensure that the requirements of the Agreement relating to Transition Planning are extended to all individuals with SPMI who are admitted to an IMD under publicly funded programs, including Medicaid. ...”

*Substance Abuse – Recommendation: Page 13 line 479:*

“The State continue to use its consultant to assist in the reorganization of substance abuse services, ... including co-occurring disorders for individuals who are at a heightened risk of institutionalization.”

*Supported Employment – Recommendation: Page 16 line 578:*

“... it has been understood that employment of people with SPMI can be realized if an expectation of work is better embedded in the service organization of providers. ... The Monitor is planning a series of additional meetings with DSAMH and DVR to chart out a course towards an ‘employment first’ model.”

### **Second Report: September 5, 2012 (Seven Separate Sets of Recommendations)**

*System Reconfiguration – Civil Commitment – Recommendation: Page 6 line 196:*

“ .... The Monitor recommends the State track changes in the following measures:

Involuntary Hospitalizations

Voluntary Hospitalizations

Outpatient Commitment Orders

“ ... The Monitor recommended that the State revise its required document for court-ordered treatment so that it includes clear information as to why less-restrictive measures are not seen as viable ...”

*Oversight of Psychiatric Hospital – Recommendation: Page 8 line 296:*

“ ... the State should begin analysis on inappropriate admissions to DPC and ... IMDs. To further expand the oversight of the EEU ...”

“... individuals who have substance abuse disorders and who do not have justifiable co-existing disorders of SPMI. The focus should be on developing a system of care that appropriately addresses their needs and rectifies the current misuse of public psychiatric beds.”

*Target Population List – Recommendation: Page 11 line 402:*

“... a department-wide overhaul of the IT systems is already underway. ... At the same time fulfillment of the Settlement Agreement requires that some data issues be immediately addressed ...”

“... resolve restrictions to accessing data from other state agencies, particularly the State’s Department of Correction. ... to allow for real-time criminal justice data about individuals on the list can enable mental health providers to intervene to prevent arrests and further involvement in the legal system ...”

“... refine plans for an upgrade of IT systems within DSAMH ...”

“Within the next few months, DHSS and DSAMH, in collaboration with the Monitor, should establish a working blueprint for addressing data requirements presented by the Settlement Agreement, including issues to be addressed in the long-range rebuild of the State’s data system and interim measures that will address the immediate IT needs.”

*Mobile Crisis Services – Recommendation: Page 13 line 463:*

“... the State needs to improve its capacity for data collection and management including its ability to capture data reflecting the time between the receipt of a request for crisis intervention and the arrival of staff on the scene.”

“In order to ensure that resources are appropriately in place statewide, data relating to response times should be tracked on a county-by-county basis, including day, time of day and specific responders.”

*Implementation of Transition Assessments - Recommendations: Page 23 line 824:*

“Through its system wide Quality Assurance (QA) program, DSAMH should carefully monitor its transition planning and implementation, particularly in instances where such planning occurs in the community following discharge from acute care. In all instances, the hospital record should either include a transition assessment consistent with what is being successfully utilized at DPC or else a specific plan for carrying out such an assessment shortly following discharge.”

“... DSAMH should monitor discharge arrangements from acute care ... to ensure that individuals are not being discharged to homelessness ... and that crisis apartments ... are being appropriately used while permanent housing needs are being evaluated and addressed.”

“Data from the Q.A. monitoring of the use of such temporary housing arrangements should be used to inform DSAMH about the adequacy of its current capacity to prevent discharge into homelessness ...  
... DSAMH should promote the routine use of DPC transition protocols within the community programs it funds.”

*Within 60 days of the Signing of the Agreement the State will make Operational – Recommendation Page 24 line 856:*

“As part of its system-wide QA, DSAMH should expand its monitoring to ensure that transition teams in IMDs appropriately include community providers and peer representatives for all publicly funded hospitalizations for individuals with SPMI.”

*Within 60 days of signing of the agreement, the State will make Operational Centralized Specialized Transition Team (Barrier Busters) including a Community Provider and Peer – Recommendation: Page 25 line 898:*

“DSAMH should expand its QA functions to assure that transitional planning in all inpatient settings occurs in compliance with the S.A. and that reviews and assistance by the centralized transition teams occur system wide.”

“DSAMH should improve its electronic data system to capture real-time data relevant to transition planning including such factors as individuals’ living arrangements at the time of hospital admission, whether the discharge is in an integrated setting and whether reviews of discharges to non-integrated settings are taking place.”

### **First Report: January 30, 2012 (Seven Separate Sets of Recommendations)**

*Stakeholders’ Understanding of the Settlement Agreement – Recommendation: Page 5 line 171: “... the State immediately launch a multi-pronged training program to ensure:*

“The workforce serving individuals with SPMI in publicly funded systems understands and can demonstrate competence in the requirements of the S.A. and the underlying principles of the ADA and the Olmstead and how they relate to daily practice.

“Consumers of services receive training and informational materials that allow them to understand their rights under the ADA and related law and have current information about the S.A. ..., and

“Courts, attorneys, advocates, and other parties involved in rights protection and the civil commitment process have a working knowledge of the ADA, Olmstead and the requirements of the S.A.”

*System Reconfiguration – Measures being taken by the State – Recommendation: Page 12 line 433:*

“The State should move as quickly as possible to introduce a comprehensive set of reforms – programmatic, administrative and legal – that will reduce unwarranted institutionalization of Delawareans with SPMI and will make far better use of public resources that are now invested in late-stage interventions and preventable hospital care...

... the State should immediately provide guidance to the Courts, attorneys representing the State in commitment actions ... and 24-hour holds be supported by specific information relating to the presence of serious mental illness, imminent danger to self or others and the absence of less restrictive alternatives.

The EEU should be expanded and established as the statewide vehicle for managing publicly funded inpatient and outpatient services for all Delawareans with SPMI and regardless of whether services are funded through DSAMH, Medicaid or other public program. ...”

*The recommendations in the section elaborate on what specifically the EEU and DSAMH should implement to coordinate all deep end services for persons with SPMI as well as diversion from inpatient hospital care.*

*Implementation of Transition Assessments and Placements: Within 30 days of the signing of the agreement, the State will re-assess all individuals currently in institutional settings – Recommendation Page 16 line 592:*

“... DSAMH should immediately develop a process whereby any individual who is hospitalized in DPC and whose team recommends a discharge other than supported housing (as defined in the Settlement Agreement) or independently living undergoes an administrative review. ...

“Within 60 days of implementing the above recommendation, the State should implement a parallel process, whereby it reviews all instances where inpatients of IMD’s with public funding are being considered for discharge to a non-integrated setting.

“DSAMH should proceed as planned to pilot its assessment protocol within DPC, and should develop a timetable to evaluate the utility of this instrument and to apply it state-wide.”

*Within 60 days of the signing of the agreement, the State will make operational transition teams including community provider and peer representatives – Recommendation: Page 17 line 627:*

“DSAMH should immediately begin random reviews of individuals within DPC and the IMDs to assure that transition teams are operational per the requirements of the Settlement Agreement. ...”

*Crisis Stabilization: By July 1, 2012, the State will ensure that an intensive services provider meets with every individual receiving acute inpatient crisis stabilization within 24 hours of admission... – Recommendation: Page 21 line 782:*

“... the State will consolidate its management of publicly funded psychiatric hospital care...”

*By July 1, 2012, the State will provide housing vouchers or subsidies and bridge funding to a total of 250 individuals – Recommendation: Page 23 line 862:*

“The State will need to secure funding for housing for an additional 50 individuals by July 1, 2012, and will need to make long-range provisions to assure achievement of the incremental goals throughout the life of the Settlement Agreement.”