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

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

9/19/2016

Karen[1] describes her life as a journey through hell and back. As a child, when she entered Delaware's mental health system, she was shy to the point that she wouldn't speak. She mostly kept her head down and stared at her feet, but would sometimes throw tantrums for no apparent reason. As an adult, she had a history of repeatedly overdosing. Within the Delaware Psychiatric Center, where Karen reports she was admitted around 30 times, she would bang her head against the brick wall. "It was torture," she said, "Like a prison. You have no freedom. I remember looking out the window and thinking 'When is it going to end?'" Karen now describes with pride how, with the assistance of the CRISP program, she has taken control of her own recovery. "I'm doing so much better now than I've ever been in my life. I get upset and I bounce right back." She lives in her own apartment in an ordinary apartment complex. She cooks and cleans and has plans to help others, perhaps as a peer specialist. "Life is wonderful now."

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Jerry had been working as an emergency responder, but after becoming seriously injured in an accident and followed by the breakup of his marriage, his life seemed to fall apart. He estimates that he tried to harm himself—through overdosing on pills or stabbing himself—about 20 times. He started drinking heavily to soothe his depression, but became a "fall down drunk." He was admitted to the Delaware Psychiatric Center several times and was diagnosed with bipolar disorder. He is now receiving outpatient mental health services and alcohol treatment and has been clean for six months. Jerry lives in his own apartment, which

[1] To protect their privacy, peers' names used in this report have been changed.

he describes as nice, and finds his treatment team to be very supportive of his recovery. He is thinking about job prospects and, while he admits to being "a little scared every day," describes himself as now optimistic. He reads a lot, stays in touch with his family, and attends to grocery shopping and other household chores.

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Susan has had a very difficult life. Beginning as a teenager, she was the victim of abuse and molestation. She has been diagnosed as having paranoid schizophrenia and guesses that she was psychiatrically hospitalized 15 or 20 times. When outside of a hospital, much of Susan's adult life was spent in homelessness. She described living in shelters, sleeping on park benches, or huddled with other homeless people; "It was scary and dangerous, but you just keep on going. Never stay in one place too long." She reported the many indignities of being homeless: trying to find a private place to relieve herself because she was denied access to restrooms; police harassing her—shooing her away, telling her to go down the street or to another city, and threatening to arrest her for vagrancy; and being looked down upon by passersby. "Try living on the streets without food and rest for days on end. Tell me how strong you're going to be," she said. And hers was a lonely life, "Most people are unable to understand me or they don't take the time to get to know me. I would hang out in bars because I didn't have any friends." Susan's life is vastly different now. For more than a year and a half, she has received supported housing services, living in her own apartment in what she describes as a "decent neighborhood, safe." This is the longest period of time that Susan has had a stable home in her adult life. Susan describes her apartment as spacious, with a washer and dryer, a garbage disposal, and dishwasher. "I have a lovely apartment; I love it." In sharp contrast to being concerned about survival on the streets, she now describes her efforts to live within her budget (she doesn't use the dishwasher to help keep her electric bill low), and she reminded herself to pick up some carpet cleaner because she had spilled something on her rug. Susan feels that her treatment team affords her dignity and respect, and describes her very close relationship with an individual providing her with peer supports. "My life is a miracle," she says.

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This is the tenth report of the Court Monitor (Monitor) on the implementation by the State of Delaware (State) of its Settlement Agreement (Agreement) with the U.S. Department of Justice (DOJ) relating to its services for individuals with Serious and Persistent Mental Illness (SPMI). The Agreement, which went into effect on July 15, 2011, requires the State to comply with the Americans with Disabilities Act (ADA), the Supreme Court's decision in *Olmstead v. L.C.* (*Olmstead*), and other laws that require public systems to support individuals with SPMI to live successfully in their communities without being subjected to unwarranted institutional segregation. In slightly longer than five years of implementing the Agreement, the State has made dramatic improvements in its services to Delawareans with SPMI. While this report presents substantial aggregate data in support of the Monitor's finding that the State is now in Substantial Compliance with the requirements of the Agreement, the stories above speak to its individual human outcomes. They reflect individuals who have struggled against incredible challenges—clinically and otherwise—and who are pursing recovery that might have been unthinkable not so long ago. Today, these individuals' lives are not dramatic; remembering to pick up some rug cleaner is a mundane matter. Yet, for these and other members of the Agreement's target population, that life could become so mundane *is* dramatic. It is also what is at the heart of the ADA, *Olmstead*, and the Agreement: affording individuals who had been relegated to the margins of society the services and opportunities they need to live ordinary lives in the community mainstream.

This report presents a detailed analysis of Delaware's success in complying with the Agreement and in achieving the kind of outcomes reported by these three individuals when they were interviewed by the Monitor in July, 2016. These individuals have made substantial progress and are now on pathways towards further improving their lives. Likewise, Delaware's service systems affecting these and other people with SPMI have made substantial progress and are on a trajectory to achieve further progress. These systems are not perfect, but they are increasingly aligned to promote recovery, self-determination, and community integration.

This report begins with information about the population of individuals targeted as the prime beneficiaries of the Agreement, followed by information about some cross-cutting systemic changes that have broadly affected implementation of the Agreement, and then a discussion of the State's compliance with regard to specific provisions of the Agreement. The State is now in Substantial Compliance with each of these provisions.

A. Target Population

Section II.B of the Agreement defines the population to be served, as well as specific sub-populations that are prioritized based upon their elevated risk of institutional segregation:

1. The target population for the community services described in this section is the subset of the individuals who have serious and persistent mental illness (SPMI) who are at the highest risk of unnecessary institutionalization. SPMI is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria and has been manifest in the last year, has resulted in functional impairment which substantially interferes with or limits one or more major life activities, and has episodic, recurrent, or persistent features.

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

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

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

   c. People who are, or have been, admitted to private institutions for mental disease ("IMDs") in the last two years;[2]

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

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

[2] IMDs are privately owned psychiatric hospitals. The IMDs currently serving the target population are Dover Behavioral Health, MeadowWood Behavioral Health, and Rockford Center. A fourth IMD is being developed in Sussex County, but is not yet operational.

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

To construct the required Target Population Priority List (TPPL), in the first year of implementation the Monitor and the State agreed on a list of psychiatric diagnoses that are indicative of SPMI. This list is included in Appendix-A. In addition, the Monitor and the State devised a set of strategies to identify an initial population for inclusion on the TPPL (e.g., individuals served through the Division of Substance Abuse and Mental Health's (DSAMH) specialized mental health programs) and for adding new individuals to the list (e.g., psychiatric hospitalization of individuals within the Medicaid program where the discharge diagnoses included one or more of those indicative of SPMI). The TPPL list grew quickly. As of December, 2016, 12,826 individuals had been identified in accordance with the agreed upon criteria.

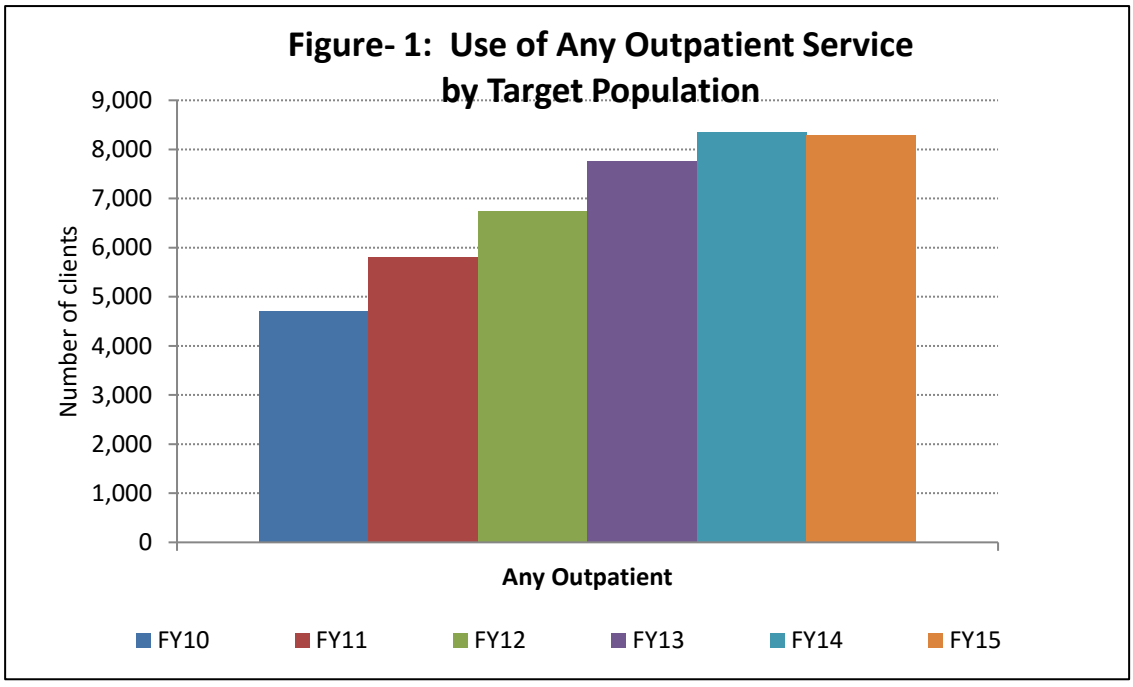
In order get a sense of the population being served and the reach of the Agreement in terms of the high-risk categories delineated above and other factors, the State has maintained data about the service histories of members of the TPPL. Table-1 presents the numbers of individuals within each high-risk

Table- 1
Breakdown of TPPL Risk or Inclusion Factors
12,826 Individuals
December, 2016

Risk or Inclusion Factor	Number of Individuals	Percent of Total TPPL
Hospitalization or History of Hospitalization at Delaware Psychiatric Center (DPC)	1,096	8.5%
Hospitalization or History of Hospitalization at a private psychiatric hospital (IMD)	7,070	55.1%
Emergency Room Use due to Mental Illness or Substance Use	4,116	32.1%
Criminal Justice Contact related to Mental Illness	2,764	21.5%
Homelessness	905	7.1%
Crisis Walk-In Center Use	1,058	8.2%
Target Care Management Use	3,086	24.1%
Group Home	254	2.0%
Intensive Community Mental Health Service Programs	2,937	22.9%
Generic Community Mental Health Programs	2,590	20.2%

category, as well as their representation as a proportion of the total TPPL. A single individual may be represented in more than one risk category.

Working in collaboration with experts from the University of Pennsylvania (UPenn)[3] the State has access to analyses of overall trends relating to the target population[4] and changes that have occurred through the course of the Agreement's implementation. As a general matter, the Agreement seeks to reduce the State's reliance on institutions such as hospitals in serving individuals with SPMI and, as is discussed in detail later in this report, it requires the development of a comprehensive array of community-based mental health programs. UPenn's analysis of Medicaid claims and other data finds that, indeed, outpatient mental health service use has increased significantly, as compared with use prior to and at the outset of implementation. Figure-1 shows that between Fiscal Year 2010[5]—the year preceding implementation of the Agreement—and Fiscal Year 2015, outpatient mental health service utilization (of any type) by people with SPMI almost doubled.

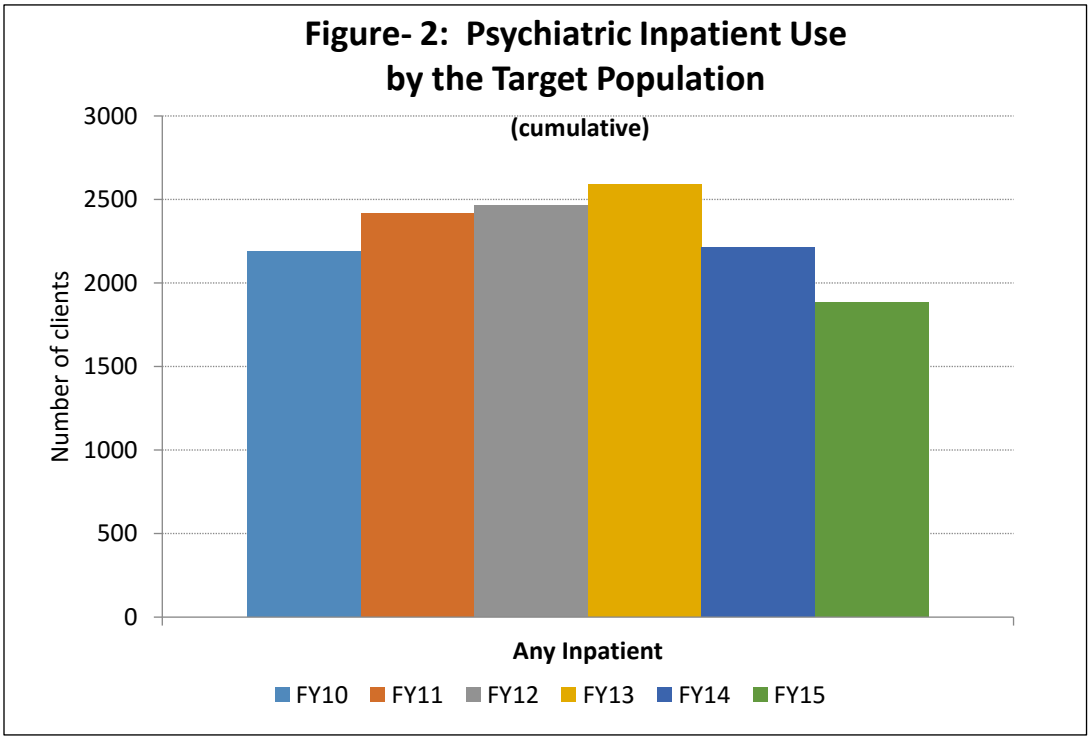


[3] Center for Mental Health Policy and Services Research, Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania.

[4] It is noted that the University of Pennsylvania employs methodology for including individuals in its analyses that slightly differs from the State's, but this difference is unlikely to significantly affect the overall trends reported.

[5] Fiscal Year (FY) 2010 runs from July 1, 2009 through June 30, 2010 and other FYs are defined accordingly.

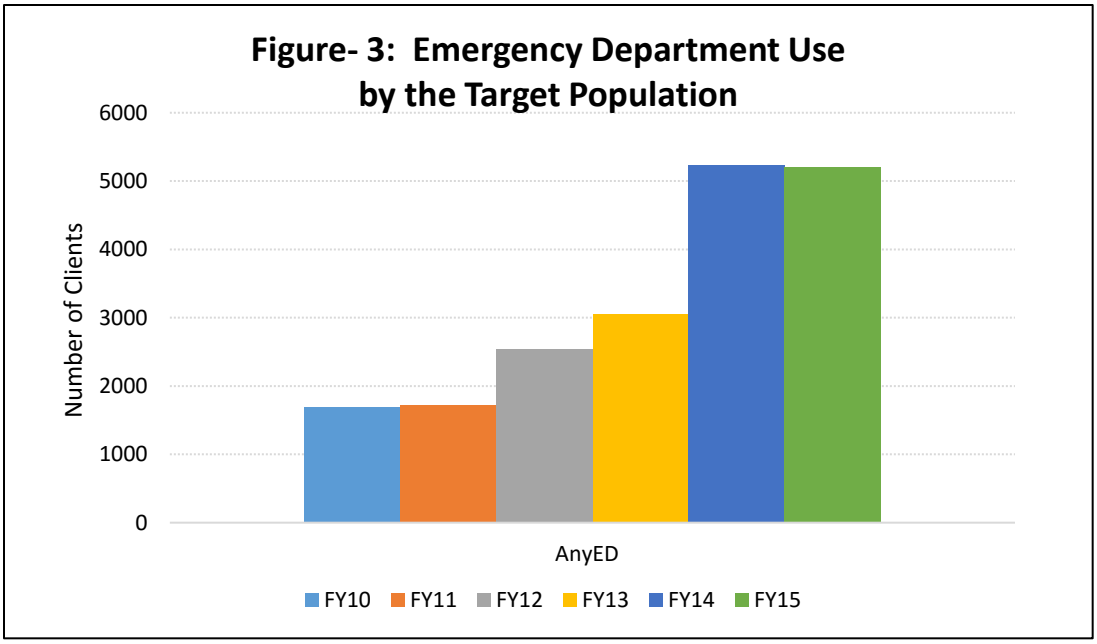
At the same time, the State was able to reduce its civil beds at the Delaware Psychiatric Center (DPC) by 42%.[6] Figure-2 summarizes use of psychiatric hospitals by the target population during the same time period. It shows that admissions to DPC or an IMD declined when Fiscal Year 2010 is compared with Fiscal Year 2015, although inpatient use increased in some of the intervening years.



On the other hand, Figure-3 shows that emergency department use rates by the target population have increased dramatically. As is discussed throughout this report, the State uses such data to drive system improvements. Based in part upon its monitoring of this trend, the State is taking actions to shift crisis evaluations from hospital emergency departments to it Crisis Walk-In Centers.[7]

[6] The bed reduction at DPC is discussed further in Section XIII of this report, which concerns Quality Assurance and Performance Improvement.

[7] It is noted that the number of individuals identified by physicians in emergency departments as having SPMI is likely inflated because of problems in differentiating mental illness from substance use in those settings. This diagnostic issue is discussed further in this report in the section, Provisions Relating to Reductions in Acute Care Bed Days.



Information provided in this report includes details of the use and outcomes of specific community services. As a general matter, these data relating to the TPPL show that the Agreement appears to have spurred a significant growth in outpatient mental health service use by the high-risk target population; in some respects, a decrease in the use of psychiatric hospitals (although the picture is more complex, as is discussed later); and a shift to emergency departments and other settings where diversion from further hospitalization may occur.

B. Structural Changes with Broad Impact

In implementing the Agreement, the State made several broad structural changes in its systems affecting the target population. Their impact cuts across specific provisions of the Agreement and they provide context for many of the State's accomplishments that are detailed later in this report. They are also important because they represent significant changes in law, policy, and decision making that have now become embedded in Delaware's service systems. As such, they enhance the strong likelihood that the reforms made pursuant to the Agreement will continue beyond its resolution.

1. Mental Health Laws-

At the outset of the Agreement, Delaware's mental health system was guided by a very antiquated set of laws that were written decades ago and that reflected an era when DPC and its Superintendent were the hub of the State's mental health system. Since the Agreement went into effect, the State has made several important legislative changes that not only update its mental health laws, but also align them with the requirements of the ADA, *Olmstead* and, more particularly, the Agreement. This legislation includes:

a. House Bill 311, which was signed into law in July, 2012. Among its provisions, this law required that, prior to an individual being detained for 24-observation to determine if involuntary hospitalization is indicated, that individual first be evaluated by a credentialed screener to determine that the individual likely has a serious mental illness and whether less restrictive measures can be put into effect. This law specifically references its intent to further the State's efforts to comply with the Agreement.

b. House Joint Resolution 17, which was passed in June, 2013, established a study group to evaluate Delaware's civil mental health laws and to make recommendations for their improvement. This study group included a broad range of stakeholders, including providers, legal and policy experts, and individuals who have lived experience with serious mental illness. The Group issued its final report in April, 2014.

c. The study group's recommendations culminated in House Bill 346, which was signed into law in October, 2014. This law significantly modernized the State's mental health code by clarifying criteria for commitment to either a hospital or outpatient treatment, ensuring that individuals are first afforded an opportunity to be served on a voluntary basis, and improving the timeliness of legal hearings.

d. Senate Bill 245, which was passed by both chambers in June, 2016. This law establishes a Behavioral and Mental Health Commission that includes a Peer Review Subcommittee charged with overseeing services to individuals with SPMI, including in matters relating to adverse events and related root cause analyses. The law focuses on the Agreement's target population,

essentially adopting the prioritization criteria discussed above, and it specifically references the requirements of the ADA with respect to individuals who have SPMI.

These laws include important protections for individuals with SPMI who receive services and they help to assure that preventing their hospitalization—whether on a voluntary or involuntary basis—remains a State priority.

2. Funding Services that Promote Community Integration-

Having successfully navigated the process for obtaining federal approval, in January, 2015, the State put into place very important changes with regard to Medicaid-covered services that enable people with SPMI to live successfully in their communities. The PROMISE program (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) vastly expanded Medicaid coverage of community services for the target population that, when they were available before PROMISE, had been totally funded with State dollars. By including these community-based and recovery-oriented services in the State's Medicaid program, Delaware is able to draw federal dollars to pay a significant portion of their costs. PROMISE comprises a comprehensive array of services, many of which are required by the Agreement, and all of which align with the Agreement's goals:

- Care management
- Benefits counseling
- Community psychiatric support and treatment
- Community-based residential supports, excluding assisted living
- Financial coaching
- Independent activities of daily living/chore services
- Individual employment supports
- Non-medical transportation
- Nursing

- Peer support
- Personal care
- Psychosocial rehabilitation
- Respite
- Short-term small group supported employment
- Community transition services

In addition to vastly expanding opportunities for capturing federal dollars in support of the Agreement's requirements, PROMISE brought two other very important benefits. Several earlier Monitor reports described the State's convoluted and uncoordinated processes within and between DSAMH and the Division of Medicaid and Medical Assistance (DMMA). The responsibility for managing hospital care for a member of the target population could shift back-and-forth between these bureaucracies, and there was no clear-cut accountability around such critical functions as averting psychiatric hospitalization for Medicaid-covered individuals with SPMI who were not served by DSAMH or referring them for DSAMH's housing or specialized mental health services. These problems significantly affected the State's ability to meet some requirements of the Agreement, particularly with respect to hospital use.[8] As a part of meeting the requirements of the federal Centers for Medicare and Medicaid Services (CMS) to implement PROMISE, this situation has significantly changed. Through collaborative agreements and new processes variously involving DMMA, DSAMH, the IMDs, and the MCOs,[9] there is now a much more systematic sharing of information and coordination of care. While these new interactions are still evolving, without question, they are much improved and will likely continue on this course.

A second benefit of PROMISE is less tangible, but perhaps equally important. The process of applying for and securing federal authorization of changes in states' Medicaid programs, such as PROMISE, is long, complex, and arduous. Partly for this reason, services covered by states' Medicaid programs tend to remain stable and do not dramatically change in short order. In interacting with a broad range of

[8] This is discussed in detail later in this report, in the section relating to Crisis Stabilization Services and Quality Assurance/Performance Improvement.

[9] MCOs are Managed Care Organizations that, under contract with DMMA, manage mental health and other healthcare benefits for the Medicaid population.

stakeholders—including peers, family members, providers, and others—the most consistent concern heard by the Monitor is not so much that there are problems in services, but far more often that stakeholders worry that the array of services introduced through the Agreement will go away once the Agreement is resolved and the State is no longer subject to a court order. In this regard, and in addition to the likely impact of the laws discussed in the prior section, PROMISE affords some assurance that the State's existing comprehensive menu of covered services will continue as elements of the Delaware's mental health service system. For all of these reasons, PROMISE has broad importance to the State's fulfillment of the requirement of the Agreement and of the ADA with regard to Delawareans with SPMI.

3. Data Systems-

Early Monitor reports referenced the fact that, as in states nationwide, Delaware's data systems relating to services for individuals with SPMI were antiquated, disjointed, idiosyncratic, and improvised. While the State had been pursuing a major overhaul of its data systems that will likely take many years to accomplish, the Agreement required a much more immediate and flexible approach. Commendably, DSAMH tapped into the talent and innovation of a data team whose achievements are evidenced in the tables and graphs that make up much of this report. The State has moved from arrangements whereby client information would be faxed between buildings on the Holloway Campus (where DPC, DSAMH, DMMA and the Health and Social Services Cabinet Secretary's offices are located) and manually tallied, to electronic information systems that can trend aggregate data over time, evaluate patterns, and drill down to the performance of specific providers. Such information has informed the parties and the Monitor about how to most effectively meet the goals of the Agreement (for instance, as is discussed later, with respect to the allocation of Assertive Community Treatment and Intensive Case Management teams). Likewise, DSAMH's decision to replicate its Ellendale Crisis Walk-In Center in the northern part of the state was based upon analyses of data regarding that program's performance and impact in reducing hospital use. As is the case with the other accomplishments discussed in this section, the State has made impressive improvements in its access to and use of data, as well as in its ability to respond to emerging data needs.

C. Ratings of Compliance with Specific Provisions of the Agreement

Table- 2: Ratings of Compliance

P=Partial Compliance S=Substantial Compliance

Requirement	Provision	I. 1/30/12	II. 9/5/12	III. 3/8/13[2]	IV. 9/24/13	V. 5/19/14	VI. 12/29/14	VII. 6/16/15[3]	VIII. 12/26/15	IX. 5/26/16[4]	X. 9/19/16
Crisis Hotline	III.A	S	S	--	--	S	S	--	S	--	S
Mobile Crisis Services	III.B	P	P	--	S	S	S	--	S	--	S
Crisis Walk-In Centers	III.C	P	S	--	S	S	S	--	S	--	S
Crisis Stabilization Svs.	III.D	P	S	--	S	P	P	--	P	MTS[5]	S
Crisis Apartments	III.E	P	S	--	S	S	S	--	S	--	S
Assertive Com. Treatmt.	III.F	P	S	--	S	S	S	--	S	--	S
Intensive Case Mgmt.	III.G	P	S	S	S	S	S	--	S	--	S
Case Management	III.H	P	P	--	S	S	S	--	S	--	S
Supported Housing	III.I	P	S	--	S	S	S	--	S	--	S
Supported Employment	III.J	--	S	--	S	S	S	--	S	--	S
Rehabilitation Services	III.K	--	S	--	S	S	S	--	S	--	S
Family/Peer Supports	III.L	--	S	--	S	S	S	--	S	--	S
Discharge Planning	II.C.2;IV.B	--	P/S[1]	--	S	P	P	--	P	S	S
Quality Assurance	V.A	P	S	--	--	S	S	--	P	S	S
Risk Management	V.B	--	--	--	--	P	P	--	P	P	S

1. The Monitor's Second Report found some provisions relating to Quality Assurance to be in Partial Compliance and others to be in Substantial Compliance.
2. The Monitor's Third Report included a compliance rating for only one provision; the Agreement specified no other new implementation targets for the time period covered.
3. The Monitor's Seventh Report focused on four areas in which the State had failed to achieve Substantial Compliance per the Sixth Report; it did not include compliance ratings of any provisions.
4. The Monitor's Ninth Report focused upon four areas in which the State had failed to achieve Substantial Compliance per the Eighth Report; it only included compliance ratings for these provisions.
5. The State was rated as being "Moving Towards Substantial Compliance" with regard to newly established criteria.

Section VI.B.3.g of the Agreement requires that the Monitor evaluate the State's success in meeting its requirements in terms of ratings of Substantial Compliance, Partial Compliance, or Noncompliance. Table-2 presents these ratings with reference to key provisions of the Agreement based upon nine previous reports, and this—the tenth—Monitor's report. As is detailed below, this report finds the State to be in Substantial Compliance with each of these key provisions.

The following sections review these provisions in detail and explain the basis for the State being rated as being in Substantial Compliance with them. Many of these discussions begin with aggregate information about the State's performance across several years, followed by more detailed current information that demonstrates how the State is able to trend performance month-to-month and to monitor key performance measures for purposes of quality control and improvement.

I. **Crisis Hotline**

Substantial Compliance.

Section III.A of the Agreement includes the following provisions:

1. By January 1, 2012, the State will develop and make available a crisis line for use 24 hours per day, 7 days per week.

2. By July 1, 2012, the State will provide publicity materials and training about the crisis hotline services in every hospital, police department, homeless shelter, and department of corrections facility in the State. The training will be developed in consultation with the Monitor.

The Crisis Hotline is a critically important element of services for people with SPMI. It provides immediate consultation and phone counseling for individuals who are in crisis and, as applicable, it can trigger intervention by Mobile Crisis[10] or other emergency services. It can also be a gateway for services for individuals who have other, less urgent service needs, and those with substance use problems that may or may not co-occur with mental illness.

The State has been found to be in Substantial Compliance with the provisions relating to the Crisis Hotline in each of the Monitor's reports for which it was rated, dating back to the first Monitor's Report in January, 2012. It remains in Substantial Compliance. Table-3 presents the average number of

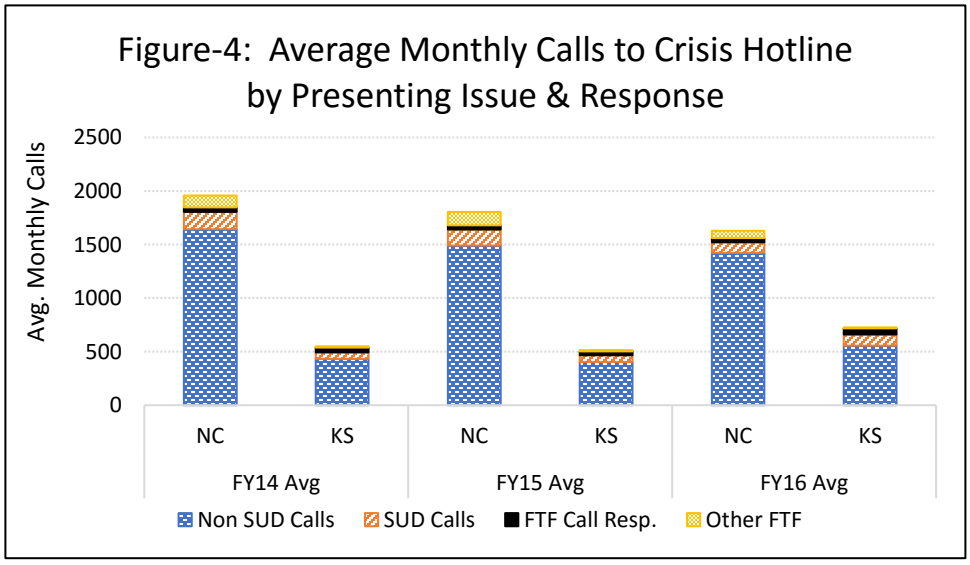
[10] Mobile Crisis teams, which are discussed in the next section, provide rapid-response, face-to-face interventions by mental health professionals.

monthly calls received by the Crisis Hotline in New Castle County (NC), where the largest number of the State's residents live, and in Kent and Sussex Counties (KS), which are in the southern part of the State and are more rural. The overall number of calls has decreased somewhat since Fiscal Year 2014, but the number of calls from Kent and Sussex have proportionally increased. In absolute numbers, a total of 28,262 calls were received in Fiscal Year 2016.

Table-3: Average Monthly Calls to Crisis Hotline by Fiscal Year and County

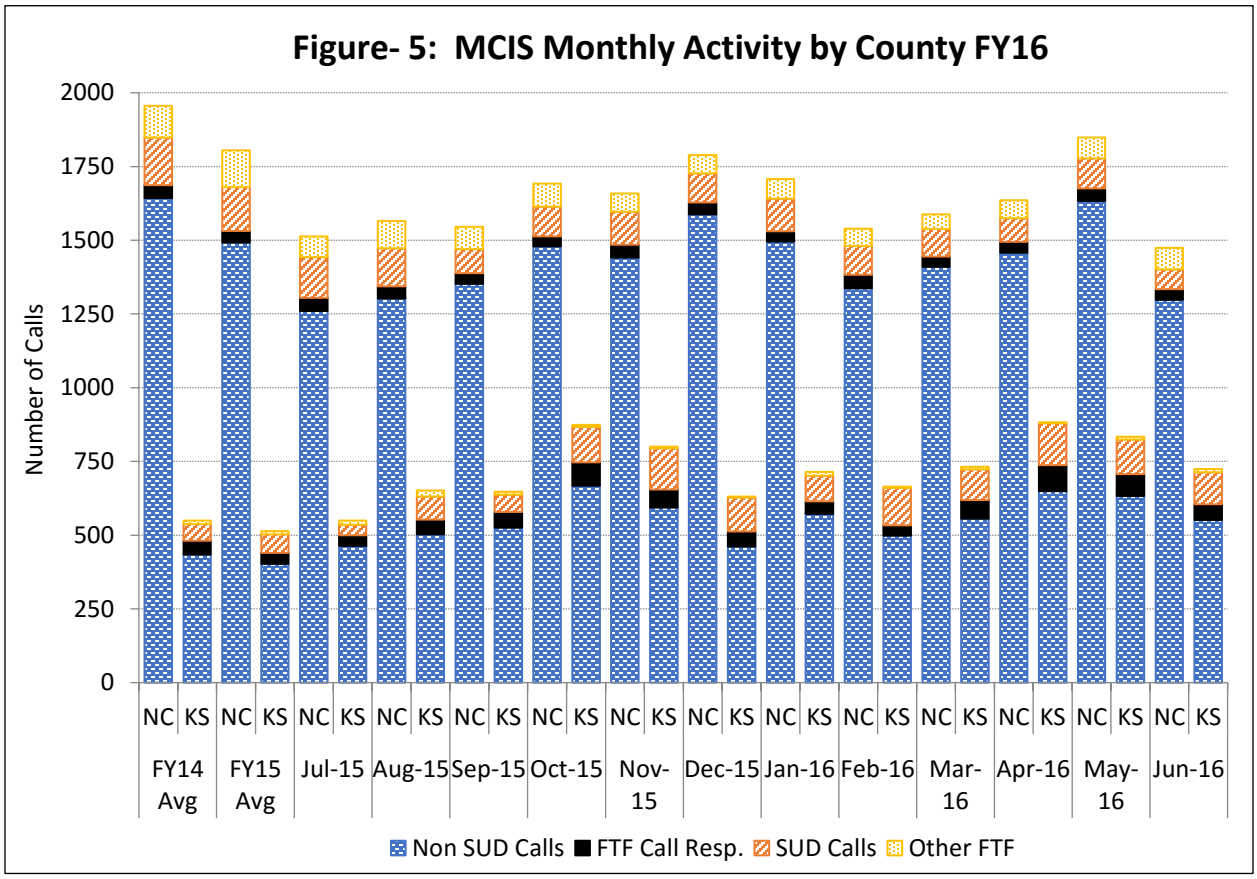
	FY14		FY15		FY16	
	NC	KS	NC	KS	NC	KS
	1,956.0	550.0	1804.9	513.5	1,629.6	725.6
Totals	2506.0		2318.4		2355.2	

Figure-4 presents a breakdown of these calls in terms of whether or not they represented issues relating to substance use (SUD); whether they were primarily related to mental health issues (Non-SUD);



whether they triggered an emergency face-to-face response (FTF Call Resp.); or whether they entail another type of face-to-face response (Other FTF), such as a wellness check.

Figure-5 demonstrates the State's capacity to more closely monitor trends on a month-to-month basis. It breaks down the above data for Fiscal Year 2016 and shows the flow of service demand in the northern and southern portions of the State.



Overall, the State's Crisis Hotline is functioning well, is integrated with Mobile Crisis and other critical elements of the mental health service structure, and is an important element of the service system addressing the needs of Delawareans who have SPMI.

II. Mobile Crisis Services

Substantial Compliance.

Section III.B of the Agreement relates to Mobile Crisis Service. It includes two elements:

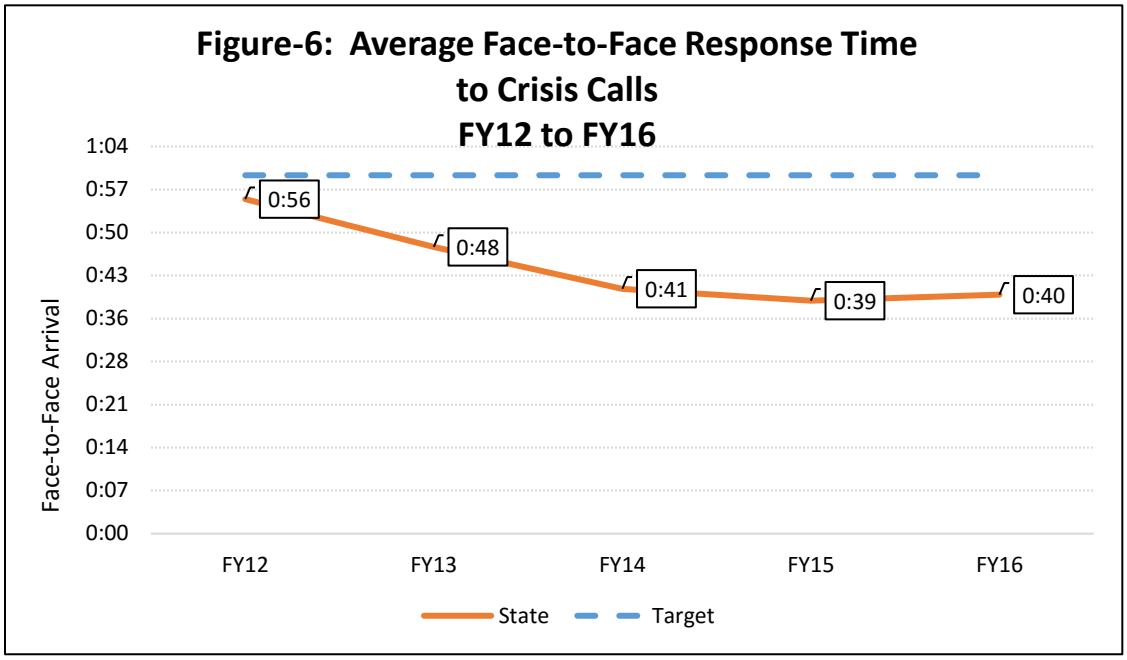
1. By July 1, 2012 the State will make operational a sufficient number of mobile crisis teams such that a team responds to a person in crisis anywhere in the state within one hour.

2. By July 1, 2013 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.

The State has been rated as being in Substantial Compliance with the requirements of the Agreement relating to Mobile Crisis since September of 2013. In the two assessments by the Monitor prior to that, it had been rated as being in Partial Compliance because the program was still being phased in.

Mobile Crisis is an extremely important service for people with SPMI in that it provides timely face-to-face interventions by trained mental health professionals and follow-up for individuals who are at very high risk of hospitalization. At its best, it assumes a role that too often used to fall to the police and that tended to result in either transport to a hospital or entry into the criminal justice system. Delaware's Mobile Crisis program is closely integrated not only with the Crisis Hotline, but also with the Crisis Walk-In Centers and with the Targeted Care Management program. The program has been an essential element of the State's overall system aimed at resolving mental health crises in ways that promote recovery and avoid unnecessary hospitalizations.

As is represented in Figure-6, the State has consistently met the requirements of Section III.B.1 that the Mobile Crisis be able to provide face-to-face interventions statewide within one hour. The State collects its data by calculating the time from when a Crisis Hotline call is completed to the time that the Mobile Crisis team meets with the individual. The average statewide response time is now about 40 minutes.



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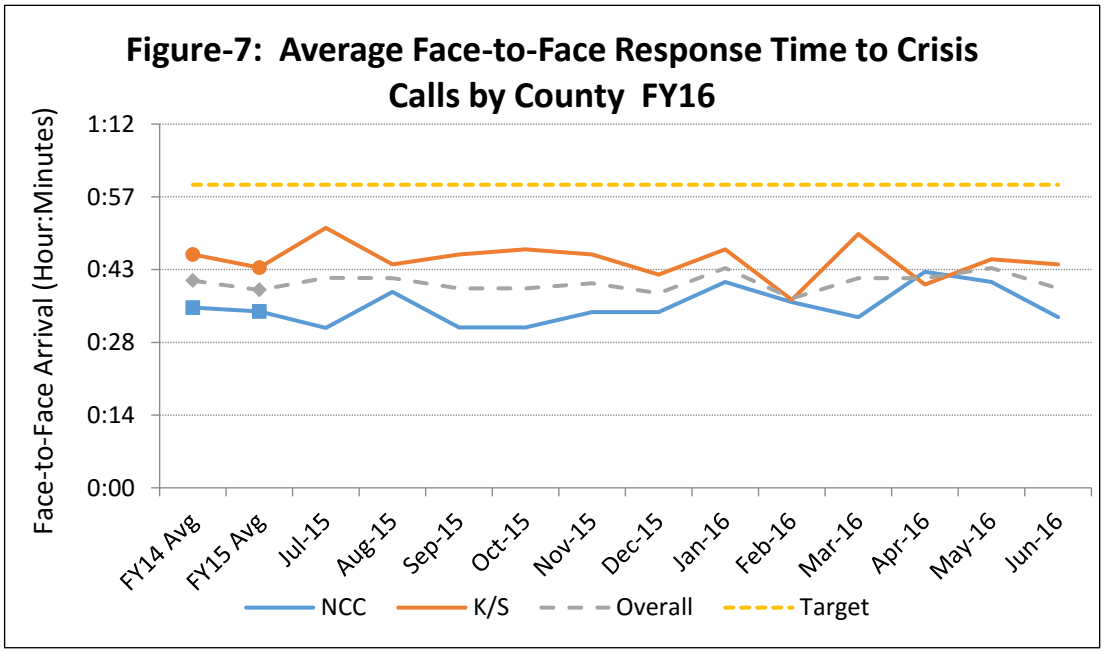
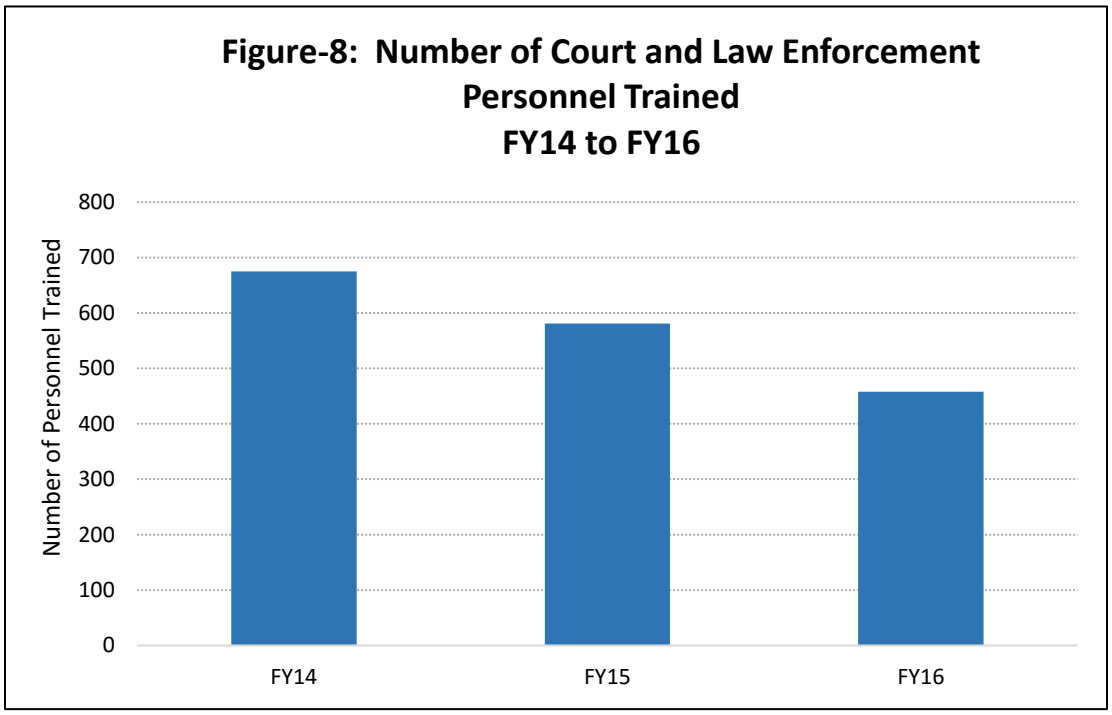
330 Figure-7 demonstrates the State's capacity to carefully monitor the flow and timeliness of Mobile Crisis
331 Services on a month-to-month basis and to track the performance of the New Castle and the Kent/Sussex
332 teams in meeting the requirements of the Agreement. Although the State is meeting the one-hour

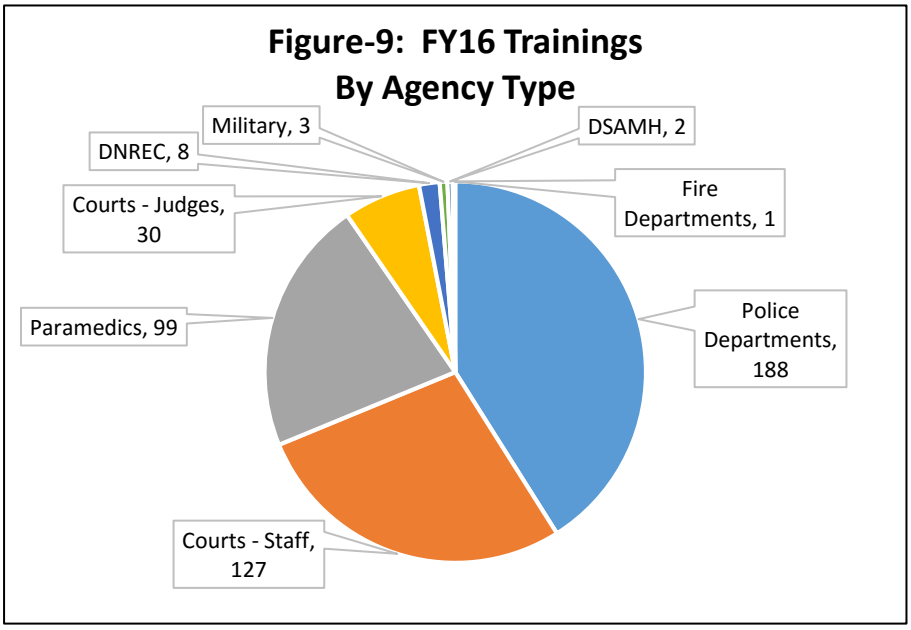


requirement across the board, not surprisingly it takes slightly longer to reach individuals in the southern counties, which have rural roads and seasonal traffic.

The Agreement recognizes the importance of Mobile Crisis becoming a resource to, and a part of, other emergency service systems in the State. Accordingly, Section III.B.2 requires that state and local law enforcement be trained in the availability of this service and the protocol for accessing it. Figure-8 presents the total number of such trainings from Fiscal Year 2014 through Fiscal Year 2016. During this 3-year period, 1,714 individuals were trained in the use of Mobile Crisis and other resources to address mental health emergencies.



These trainings range in size from single consultations with rural police departments to trainings for hundreds of participants in New Castle County. In addition to law enforcement, the State's training relating to Mobile Crisis also includes mental health providers, judges and court staff, paramedics, fire departments, and even representatives from the Department of Natural Resources and Environmental Control (which oversees State parks), and members of the military from the Dover Airforce Base. Figure-9 presents a breakdown of the audiences for these trainings in Fiscal Year 2016.



III. Crisis Walk-in Centers

Substantial Compliance.

Section III.C of the Agreement includes provisions relating to Crisis Walk-In Centers:

1. In addition to the crisis walk-in center in New Castle County serving the northern region of the State, by July 1, 2012, the State will make best efforts to make operational one crisis walk-in center in Ellendale to serve the southern region of the State. The crisis center in Ellendale shall be operational no later than September 1, 2012.

2. By July 1, 2013 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.

The State has been found to be in Substantial Compliance with these provisions of the Agreement since September of 2012.

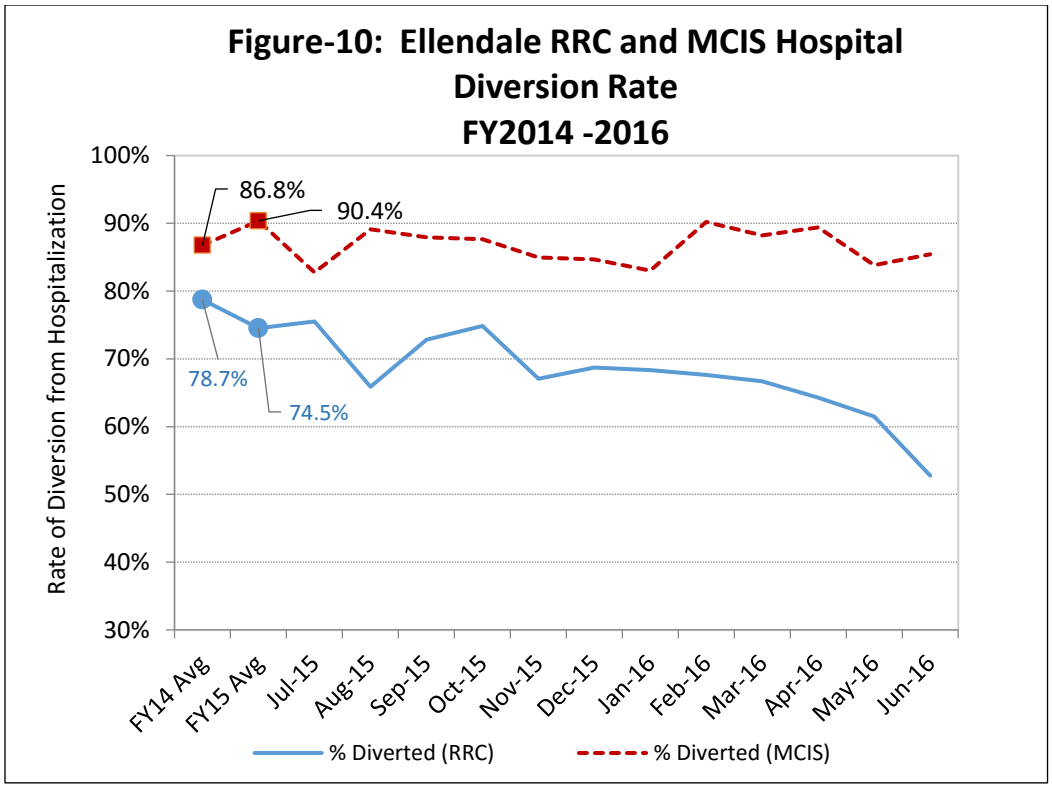
At the outset of the Agreement, the State had been operating only one Crisis Walk-In Center, which was located in New Castle County. That program, "CAPES," operated in accordance with a model that has been used for decades nationwide, whereby a part of a general hospital's emergency department provides mental health assessments and is associated with a small inpatient psychiatric unit. No such service was available in Kent and Sussex Counties. In fulfilling Sections III.C.1, in August of 2012, DSAMH opened a second crisis walk-in center in the city of Ellendale to serve the southern part of the State.

This program, called the Recovery Response Center (RRC), differed significantly from the CAPES hospital-based model. While similarly staffed with mental health professionals, the RRC also has a heavy emphasis on employing trained mental health peers—that is, individuals who themselves have lived experience with serious mental illness and, often, psychiatric hospitalizations and other traumatic events that are common among the members of the target population. Furthermore, unlike operations typical within hospital settings, the RRC follows what is called the "living room model," which offers a relaxing environment (with sofas and recliners, rather than gurneys) and, while not foregoing clinical diagnoses and treatment, encourages individuals to tell their own stories about what is happening to them. The RRC is intended to promote individuals' recovery plans and to avert hospital admissions whenever possible. It does not have an inpatient unit. With a capacity for 10 individuals, people can stay at the RRC up to 23 hours and, if hospitalization is not required, they can return home or go to another integrated crisis program (such as Crisis Apartments, discussed later).

The RRC provides DSAMH with detailed monthly statistics that allow tracking of its utilization and outcomes. The program has performed impressively—so much so, that the State decided to replace its New Castle Crisis Walk-In Center (CAPES) with a Recovery Resource Center to serve the northern part of the State. After significant construction-related delays, the new RRC opened in the city of Newark in July, 2016, and has a capacity to serve up to 16 individuals at a time.

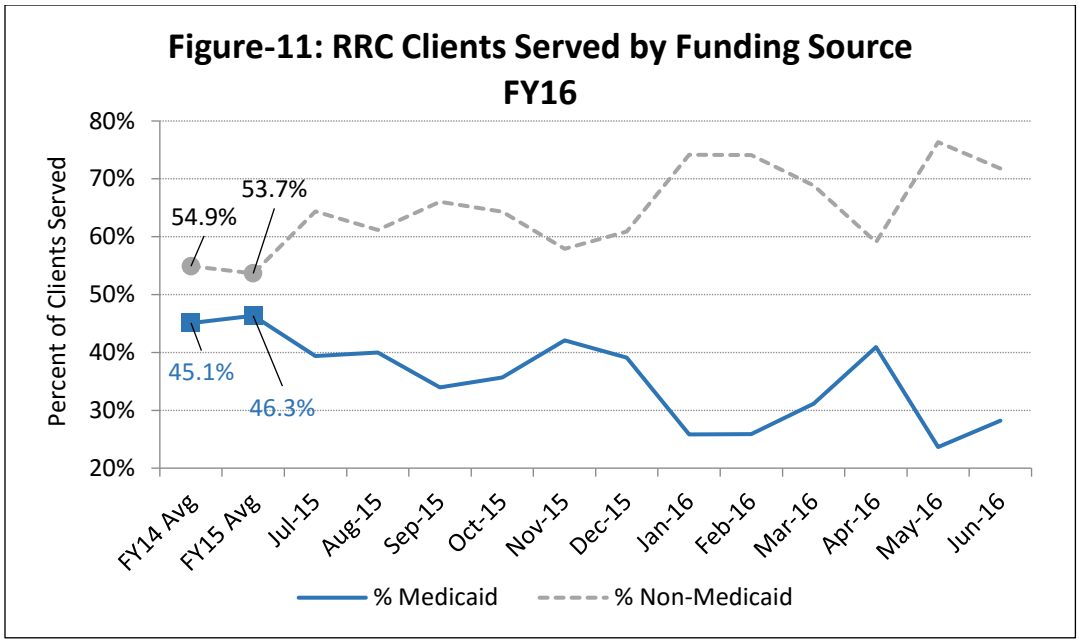
Figure-10 presents the rates of diversion from hospitalization of people served through the Ellendale RRC[11] and the statewide Mobile Crisis program. It includes annual averages for Fiscal Years 2014 and 2015, and monthly data for Fiscal Year 2016. Diversion rates for Mobile Crisis have been consistently

[11] The Newark RRC has not been operating long enough to produce meaningful data.



very high, tending to be in the high 80% to low 90% range. Diversion rates from the Ellendale RRC have tended to be in the mid- to high-70% range, but have been dropping significantly during the 2016 Fiscal Year, an outcome that the State and the provider are now carefully examining. The availability of performance data has not only allowed the State and the provider to become aware of changes in the program's diversion rate, but will also enable them to track the impact of corrective actions that are now underway.

Mobile Crisis and Crisis Walk-In Center Services are available to anyone, regardless of whether they have commercial insurance, are covered by Medicaid, or have no insurance and are funded via DSAMH. The State's Medicaid program covers services provided at its Crisis Walk-In Centers and the RRC is in the process of becoming approved for such reimbursement. Figure-11 presents the State's tracking of the Medicaid status of individuals being served at the RRC. Although trending lower this fiscal year, about 45-46% of individuals served in the past two fiscal years have been covered by Medicaid. Over 50% of people seen in those years have either commercial insurance or are uninsured, and this group is increasing in Fiscal Year 2016.



404

405 The RRC maintains detailed data about service utilization. Table-4 provides an example of some of the
406 data it captures, presenting the source of referrals received during June, 2016. The overwhelming
407 number of referrals—74.2% —come from general hospital emergency rooms, a finding that is consistent
408 with the UPenn data presented earlier. Ideally, individuals in mental health crises would come directly

409

Table-4: Referral Sources Ellendale RRC
June, 2016

Referral Source	Count	Percent
General Hospital Emergency Room	121	74.2%
Law Enforcement	14	8.6%
Self or no referral	10	6.1%
Mobile Crisis Team	8	4.9%
Emergency Medical Services (EMS)	3	1.8%
Outpatient community mental health provider	3	1.8%
Family/friend	2	1.2%
Case Management (not Recovery Innovations)	1	0.6%
Residential Facility (less than 24 hour)	1	0.6%
Total:	163	

to a Crisis Walk-In Center and would not go to a hospital emergency department. On the one hand, this is a positive finding important because direct transfers from hospital emergency rooms to IMDs—where stays are lengthier and considerably more expensive—used to be the norm and there had been little opportunity for diversion from psychiatric hospitalization. The State is encouraging direct utilization of the Crisis Walk-In Centers by emergency responders (e.g., via the trainings referenced above). Again, its access to data such as this (and Figure-3, which shows increasing emergency room use by the target population) enables the State to monitor the impact of these trainings and other efforts to reduce unnecessary use of hospital emergency departments for individuals in mental health crises.

As has been discussed in prior Monitor reports, the State has taken important measures to differentiate evaluations occurring pursuant to 24-hour mental health holds (a part of the civil commitment process) from actual hospital admission and treatment. The RRC reported that in the month of June, 2016, 119 (about 66% of those referred) were on such involuntary status when they came to the program. The RRC carried out this function outside of a hospital where, as was noted in past Monitor reports, inpatient admission has been a virtual certainty. 50.4% of these individuals were ultimately hospitalized involuntarily in June, 2016 (as presented in Figure-10, the diversion rate has historically been higher, and the hospitalization rate has been lower). RRC's data submission does not clearly show how many—if any—of the remaining individuals were hospitalized on a voluntary basis. As this practice continues in southern Delaware and becomes routine in the new northern Delaware RRC, it may show a significant impact in reducing hospital use by people with SPMI.

The RRC maintains data relating to 30-day recidivism to its program. The rate reported in June, 2016 was 11.46% (18 readmissions).

Without question, the Ellendale RRC has become a significant resource to Kent and Sussex Counties and, as its "living room" model becomes operational statewide[12] with the recently opened New Castle County program, Delaware will have access to important data about the impact of this model—both from the quantitative perspective of reducing hospital use by people with SPMI, and also qualitatively in terms of its non-traumatizing, recovery-oriented focus. Such information can drive further

[12] While living room model walk-in centers exist in some other localities in other states, Delaware is apparently the first state where this service is statewide.

programmatic and systemic refinements and should be incorporated into the State's ongoing Quality Assurance/Performance Improvement efforts.

IV. Crisis Stabilization Services

Substantial Compliance.

Section III.D of the Agreement includes targets with respect to Crisis Stabilization Services:

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

2. By July 1, 2013 the State will train all provider staff and law enforcement personnel to bring people experiencing mental health crises to crisis walk-in centers for assessment, rather than to local emergency rooms or IMDs.

3. By July 1, 2014 the number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 30% from the State's baseline on the Effective Date of the Settlement Agreement as determined by the Monitor and the Parties.

4. By July 1, 2016 the number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 50% from the State's baseline on the Effective Date of the Settlement Agreement as determined by the Monitor and the Parties.

The Agreement defines Crisis Stabilization Services as acute inpatient psychiatric care lasting 14 days or fewer that is directed towards resolving mental health crises and preventing long-term psychiatric hospitalization. The State faced significant procedural and administrative obstacles in coming into compliance with the Crisis Stabilization and acute bed use provisions. In response, the parties negotiated revised measures with respect to the targets for reductions in inpatient bed days (Sections

III.D.3-4). Delaware has made significant improvements, particularly over the past year, and in the May, 2015, Monitor's report, it was rated as "Moving Towards Substantial Compliance"—as is explained later, mostly because revised measurement strategies that were agreed to by the parties were not yet sufficiently in place. At this time, the State has made progress to the point that it can now be rated as being in Substantial Compliance with the Agreement's Crisis Stabilization requirements.

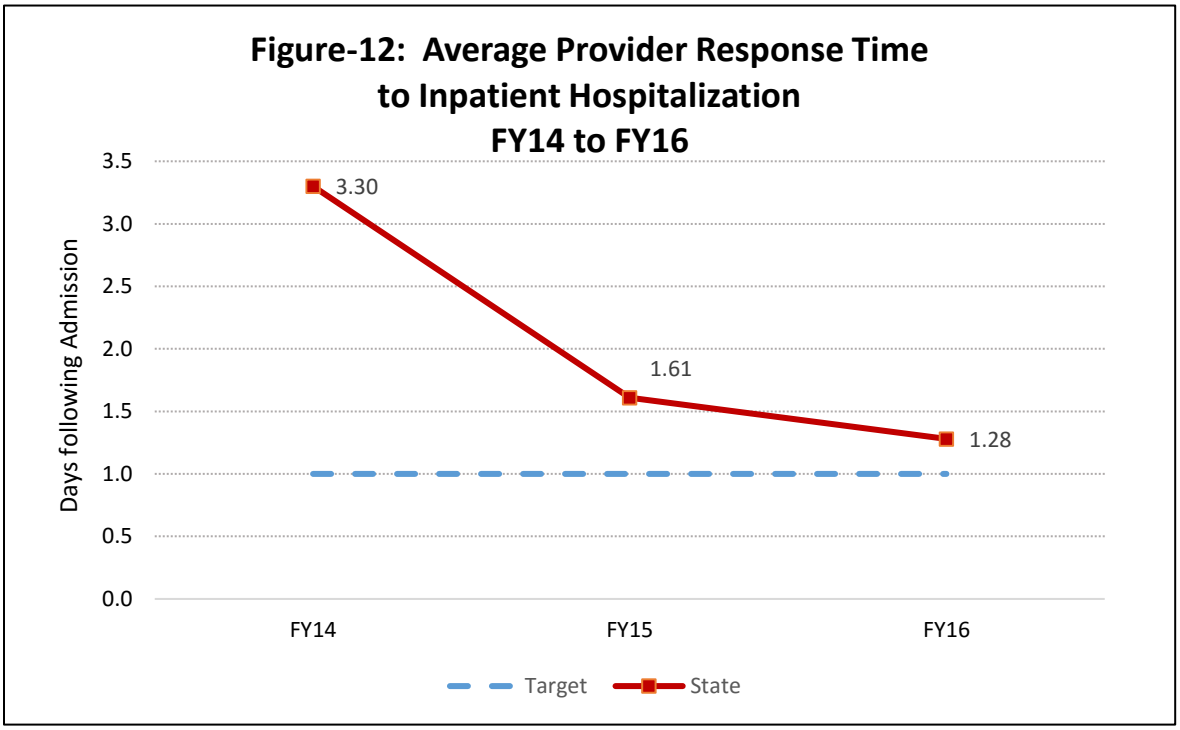
A. Community Provider Involvement

Section III.D.1 requires that by July 1, 2012, an "intensive services provider" meet with an individual within 24 hours of admission to a psychiatric hospital in order to facilitate a timely return to the community. Section II.D.2 defines "intensive support services" as Assertive Community Treatment (ACT), Intensive Case Management (ICM), and Case Management (which the State refers to as Targeted Care Management, or "TCM"). To briefly summarize the course of implementing this provision, early on the State required that service providers operating under contract with DSAMH (i.e., the programs providing ACT, ICM, and TCM) meet with individuals whom they were serving and that TCM be available to meet with newly referred individuals, both at DPC and in the IMDs. One problem was that, particularly in the IMDs, very large numbers of individuals who were diagnosed with SPMI upon admission and were covered by Medicaid (and were therefore, putative members of the target population) did not have intensive service providers affiliated with them and, furthermore, might not be determined upon discharge to have SPMI.[13] Ultimately this issue was resolved when the State adopted specific triggers for referring individuals for intensive support services.[14]

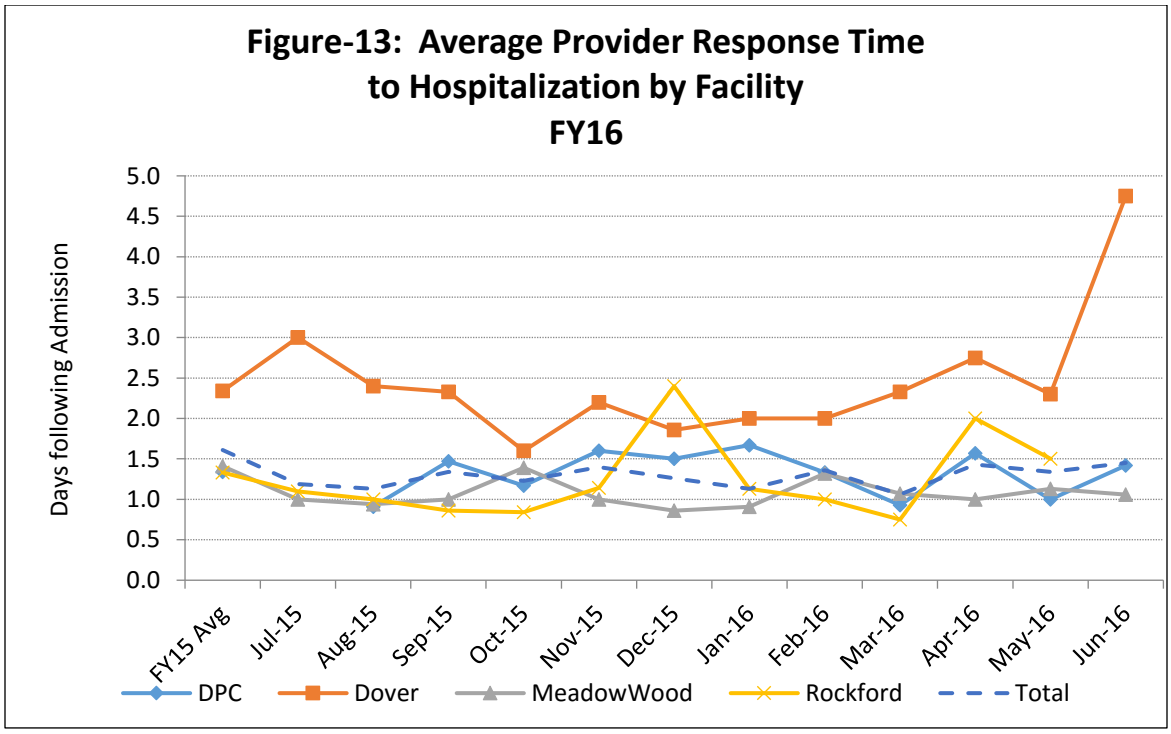
In addition, in evaluating the impact of involvement by community providers, the State recommended that for hospitalized individuals who were already receiving community services, far more urgent than contact with a case manager from an intensive support service provider was communication between the community psychiatrist and the hospital psychiatrist (which could take place via telephone). Accordingly, DSAMH required that such communications occur and they were adopted as a part of measuring compliance with III.D.1. Figure-12 presents data on the statewide averages for timeliness of community provider consultations—including doctor-to-doctor communications—when an individual is

[13] This was not the case with people already being served by DSAMH, who had well-established SPMI diagnoses.
[14] This is discussed later in the section "Provisions Relating to Reductions in Acute Care Bed Days," specifically the subsection "Engagement in Community Services."

hospitalized. Incorporating clearer processes for addressing individuals who do not have community providers (e.g., applying triggers for referral to specialized services) and doctor-to-doctor consultations, the State has not only improved the quality of these contacts, but it has dramatically improved their timeliness.



The State's data system allows it to analyze differences in the timeliness of provider involvement at each of the IMDs and at DPC, which can reflect not only the responsiveness of the community providers, but also the diligence of hospital staff in seeking their consultation. Figure-13 presents these data. Most significantly, consultations tend to be less timely at Dover Behavioral Health, which serves the southern counties. The State is closely monitoring the issue and has tentatively determined that at least a part of this trend reflects the fact that there are far fewer community psychiatrists in Southern Delaware, and their availability for consultation may be more limited than in other parts of the state. In any event, as is reflected in Figure-12, the trajectory for the State's overall compliance with the requirements of III.D.1 is favorable to the point that it can be considered to be in Substantial Compliance with this provision.



B. Stakeholder Training

Section III.D.2 requires that the State train providers and law enforcement staff in the utilization of the Crisis Walk-In Centers for assessment. Its compliance with this provision is incorporated in training that occurs pursuant to Section III.B.2, which was discussed above. The State is in Substantial Compliance with provision III.D.2.

C. Provisions Relating to Reductions in Acute Care Bed Days-

Sections III.D.3-4 of the Agreement require reductions in the number of inpatient bed-days used by the target population and paid for in whole or part with State funds. These provisions are important; their essential intent was to measure the collective impact of the array of community services and reforms resulting from the State's efforts to meet its *Olmstead* obligations to people with SPMI in not only diverting them from unnecessary hospital admissions, but also averting crises that put them at risk of

institutionalization. In other words, the rationale was that if the State systems serving people with SPMI were working in accordance with the Agreement, greater numbers of these individuals would be living stably within the community and the demand for acute care would drop accordingly. For a number of reasons, the State has not been able to achieve this goal, at least when measured in terms of the criteria contained in Sections III.D.3-4. Previous Monitor reports covering the past five years have described in detail the various factors and developments that have affected the State's failure to meet the targets contained in the Agreement, as originally constructed. The most significant among them are summarized as follows:

- For most of the Agreement's implementation period, responsibility for oversight and monitoring psychiatric hospitalizations of the target population was convoluted and diffuse, spread across DSAMH, DMMA, and the MCOs. The State had shown progress in reducing acute hospitalizations among individuals receiving specialized mental health services via DSAMH and when DSAMH managed their inpatient care. In general, however, bed-days relating to acute psychiatric hospitalizations among individuals diagnosed with SPMI whose care had been managed through DMMA and the MCOs tended to increase, rather than decrease.

- PROMISE not only expanded Medicaid coverage for community services critical to the target population, but also entailed collaborative agreements and new processes intended to address gaps and inefficiencies that had affected hospital use by the target population. While the State has been moving aggressively to implement PROMISE since it was authorized by the federal Centers for Medicare and Medicaid Services, this is a complex initiative and the full array of covered services is not yet fully available. As such, while it is very likely that PROMISE—once fully operational—can and will reduce psychiatric hospital use by the target population (and have other important benefits relating to *Olmstead* compliance, as well), realistically it will be some time before its impact is demonstrated in hospital bed-use decreases.

- Multiple informants from several stakeholder groups (including providers and MCOs, and also substantiated by the Monitor's clinical record reviews) have suggested that, due to limited information at the time of an individual's hospital admission or perceptions by IMD providers that authorization for Medicaid reimbursement would be more certain, individuals who likely did not have SPMI when entering the IMDs were nevertheless given SPMI diagnoses. Accordingly,

perhaps a significant number of individuals who were hospitalized, so diagnosed, and included on the TPPL, have inflated the true numbers of hospital bed-days affecting the population to which the Agreement is actually directed.

- The number of individuals prone to such misdiagnosis increased due to an epidemic of substance use in Delaware (and elsewhere). In addition, perceptions about Medicaid coverage and reimbursement rates for substance use treatment, and a shortage of substance use treatment beds further contributed to a climate whereby individuals were questionably diagnosed with SPMI, psychiatrically hospitalized, and counted with respect to Sections III.D.3-4 compliance.

In light of these and other factors, it became clear to the Monitor and the parties that, notwithstanding the State's success in meeting—and, in some instances, surpassing the requirements of the Agreement with regard to developing comprehensive community services, as well as its efforts (e.g., via PROMISE) to address some of the structural issues affecting hospital bed use by the target population, realistically it would not be able to meet the targets contained in Sections III.D.3-4 any time soon. Accordingly, the Monitor, DOJ and the State held a series of discussions to explore how—without compromising the underlying intent of the Agreement's bed-day measurements—alternative approaches might be established to document the State's efforts to reduce psychiatric hospital bed use by people with SPMI. In February, 2016, the parties agreed that the State's compliance with Sections III.D.3-4 would be evaluated not only with regard to acute hospital bed-day counts, but also with regard to a comprehensive set of additional measures reflecting hospital use, hospital diversion activities, and measures to address critical risk factors.

The State is in Substantial Compliance with Sections III.D.3-4, based upon this expanded set of measures. Because they are now incorporated in the State's Quality Assurance and Performance Improvement (QA/PI) program, detailed discussion of the State's findings and actions relating to the revised set of measures is presented in the QA/PI section of this report (Section XIII).

V. Crisis Apartments

Substantial Compliance.

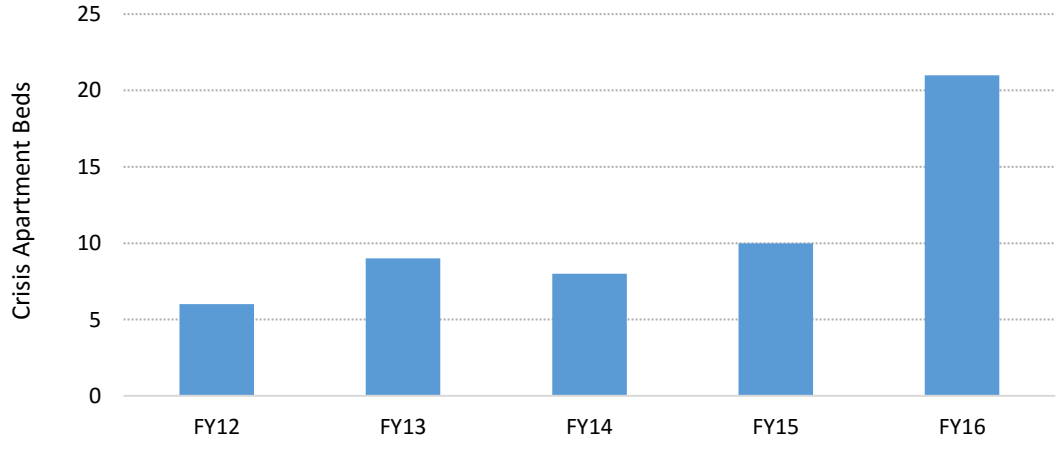
Section III.E of the Agreement includes provisions relating to crisis apartments:

1. By July 1, 2012 the State will make operational two crisis apartments. [15]

2. By July 1, 2013 the State will make operational a minimum of two additional crisis apartments, ensuring that the four apartments total are spread throughout the State.

Crisis apartments are an important community alternative for individuals with SPMI who are at risk of hospitalization. They are staffed by trained mental health peers; clinical and other services are provided by ACT teams, TCM, and other providers. The State has been found to be in Substantial Compliance with the Agreement's requirements relating to Crisis Apartments since September, 2012, and it remains so today. In fact, it has consistently—and significantly—exceeded the targets contained in the Agreement. In Fiscal Year 2016, the State operated in 7 Crisis Apartment units, which exceeds the requirements of Section III.E.2 by 75%. As is represented in Figure-14, in Fiscal Year 2016, DSAMH's

Figure-14: Number of Crisis Apartment Beds FY12 to FY16



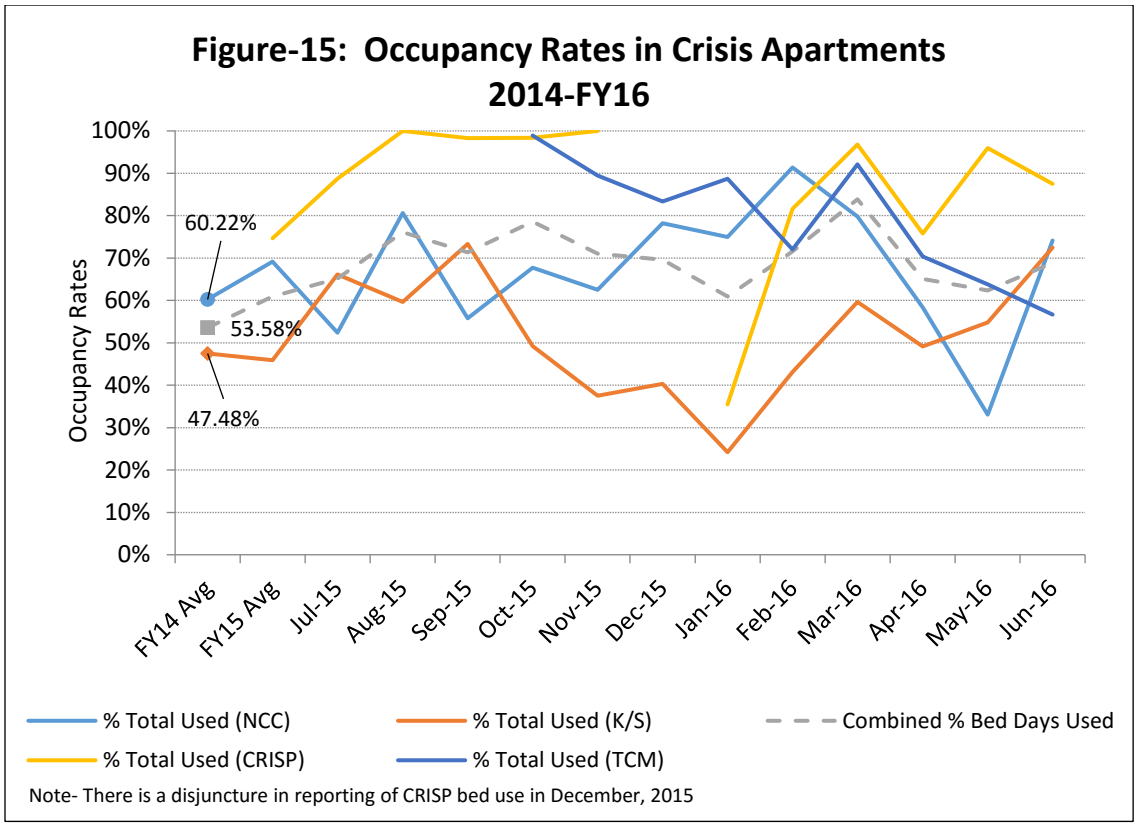
[15] The Agreement does not define the number of beds required in each Crisis Apartment, nor does it include a standard for occupancy rates.

Crisis Apartment program has 21 beds available statewide. The program includes Restart Respite Apartments, which are operated by Recovery Innovations (the provider that also operates the RRC Crisis Walk-In Centers), with locations in both the northern and southern parts of the state. It also includes 4 beds that are affiliated with the CRISP program (discussed in the section relating to Assertive Community Treatment) and 9 beds associated with the Targeted Care Management program.

The Agreement contemplates that individuals will stay in Crisis Apartments for up to seven days, but in practice many people utilizing these beds have unstable housing; they remain longer than that as permanent living arrangements are put into place.

The State has been monitoring utilization of Crisis Apartment beds because they represented a new resource for the system and it was unclear what the demand and needed capacity would be. Initially, the Crisis Apartments had significant vacancy rates, but the State took measures to better integrate the program with its community service structure—for instance, notifying Mobile Crisis Teams of bed availability—and utilization has been trending upward. Figure-15 presents the State's detailed trending of bed utilization by program, with annual averages for Fiscal Years 2014 and 2015, and monthly trending for Fiscal Year 2016. CRISP and TCM Crisis Apartments were not counted until 2015.

In summary, the State has exceeded the requirements of the Agreement with respect to Crisis Apartments. The program is well integrated with its larger crisis system (e.g., Mobile Crisis and the Crisis Walk-In Centers), and the beds affiliated with Targeted Care Management allow ready access for individuals who are just becoming linked to specialized mental health services and who may be living in very unstable living environments. It is monitoring this program and its relationship to other services to ensure that it is being appropriately utilized and that capacities align with service needs. The program is in Substantial Compliance with Section III.E.



VI. Assertive Community Treatment & Intensive Case Management

Substantial Compliance.

Assertive Community Treatment (ACT) and Intensive Case Management (ICM) are among the elements of the Intensive Support Services that are defined in Section II.D of the Agreement. Sections III.F and III.G lay out specific targets in terms of the number of teams required for ACT and ICM, respectively.

Section III.F

1. By July 1, 2012 the State will expand its 8 ACT teams to bring them into fidelity with the Dartmouth model.
2. By September 1, 2013 the State will add 1 additional ACT team that is in fidelity with the Dartmouth model.

3. By September 1, 2014 the State will add 1 additional ACT team that is in fidelity with the Dartmouth model.
4. By September 1, 2015 the State will add 1 additional ACT team that is in fidelity with the Dartmouth model.

Section III.G

1. By July 1, 2012 the State will develop and begin to utilize 3 ICM teams.
2. By January 1, 2013 the State will develop and begin to utilize 1 additional ICM team.

The State has been in Substantial Compliance with both ACT and ICM requirements consistently since September, 2012. As has been discussed in prior Monitor reports, though, some modifications of these provisions have been proposed and agreed to by the parties. First of all, early on the State requested that in place of the Dartmouth fidelity standards, the Tool for Measurement of Assertive Community Treatment (TMACT) be used because it more closely aligns with the recovery orientation that DSAMH is promoting in its programs. TMACT fidelity monitoring has taken place throughout the implementation period.

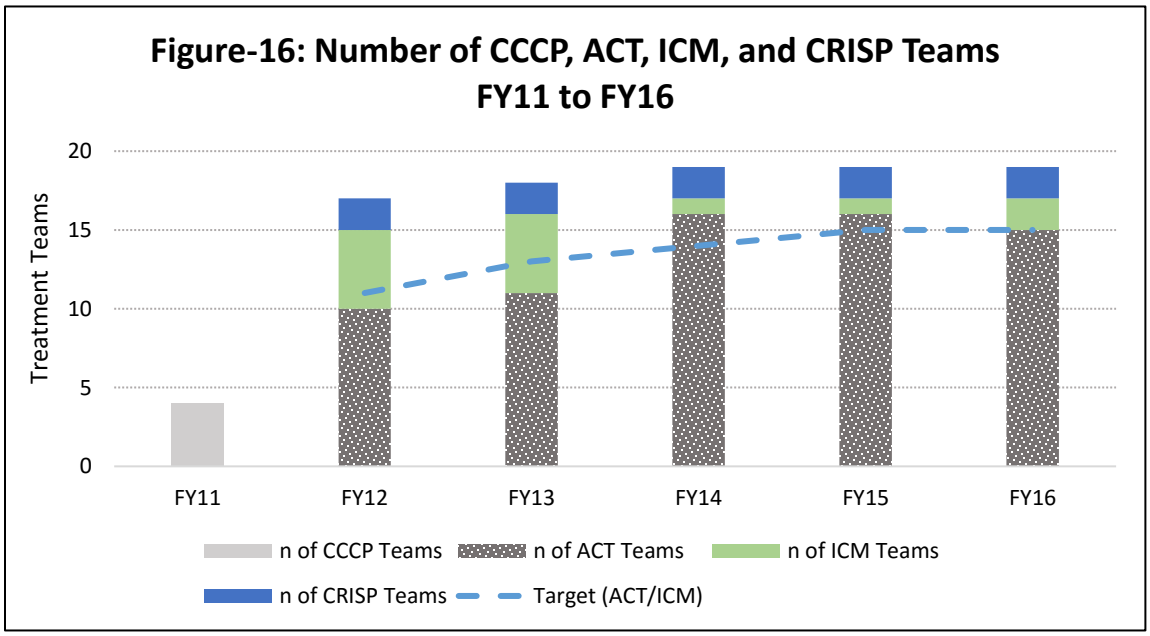
Secondly, the State has met and sometimes surpassed the requirements of the Agreement with respect to ACT, but it has also found that ICM—which is a less intensively staffed level of service—was not always meeting the needs of the individuals actually assigned to the program. Accordingly, with agreement by the Monitor and DOJ, it upgraded some of its ICM teams to ACT levels, essentially providing services to some of the ICM population at an intensity beyond what Section III.G requires. It has since made further adjustments—to higher and lower levels of service—based upon the assessed needs of individuals being served.

Finally, although not required by the Agreement, in 2012 the State initiated the CRISP program (Community Reintegration Support Project), which was directed at individuals with levels of need beyond what was available through ACT. Many such individuals were clinically stable, but remained in DPC because no program could provide the needed services. CRISP programs are reimbursed on a capitated basis, which allows providers to use funds innovatively to meet the needs of the people served, including clinical and other services, rental costs, transportation, and other expenses. CRISP programs

are also liable for inpatient psychiatric expenses, and are thus incentivized to create alternatives (such as the CRISP Crisis Apartments). They operate similarly to ACT programs and are an important part of DSAMH's service array.

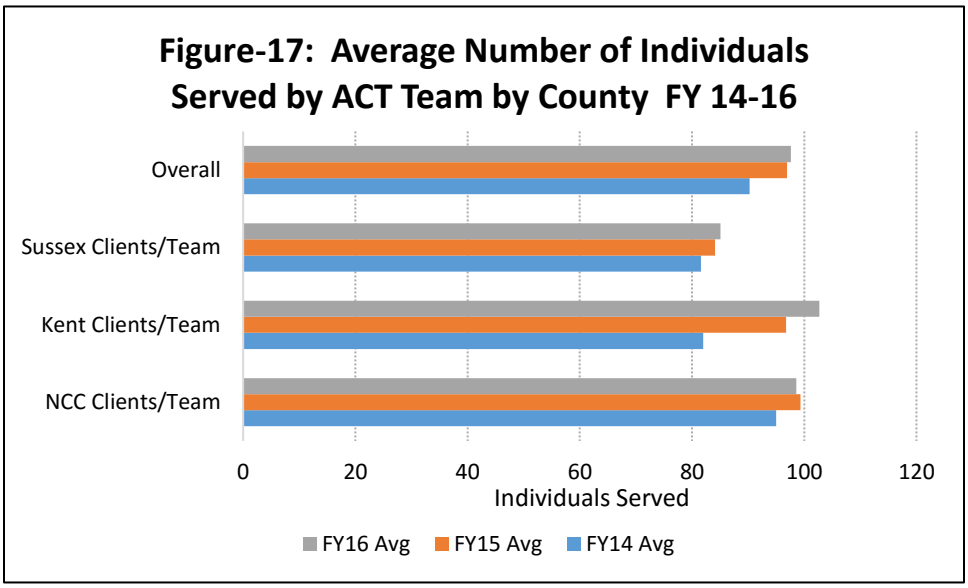
In summary, ACT, ICM, and CRISP are all intensive programs that are directed at individuals who have SPMI and the highest levels of disability. These programs provide mobile, out-of-office services and are available on a 24-hour basis. Each of them enables members of the target population to live in ordinary housing and to pursue mainstream employment. Sections III.F and III.G differentiate ACT from ICM; they do not address CRISP even though it entails similar levels of service. Furthermore, the shifts between ACT and ICM and the additional resources that the State has dedicated to these intensive services have made it extraordinarily complicated to reconcile the services being provided with the Agreement's numerical targets. For all of these reasons, and with agreement by the parties, the evaluation of compliance with Sections III.G and III.F is being consolidated and CRISP services are being incorporated in consideration of the State's fulfillment of these provisions' requirements.

Figure-16 presents the number and configuration of ACT, ICM, and CRISP teams from Fiscal Year 2012 through Fiscal Year 2016. For comparison, it also includes the number of intensive service teams (called CCCP) that were operating in Fiscal Year 2011, at the outset of implementation. The dashed line



labelled as "Target" indicates the combined number of treatment teams per sections III.F and III.G that were required for each year the Agreement has been in effect. As is reflected in this Figure, the State has consistently exceeded the Agreement's requirements. In Fiscal Year 2016, it had operational 15 ACT teams, 2 ICM teams, and 2 CRISP teams.[16]

ACT services have been heavily utilized and vacancies are relatively rare. The State monitors the number of clients served by teams in the three counties, as is presented in Figure-17. Teams are designed to serve approximately 100 individuals, although in Sussex County the State has configured teams to serve fewer individuals to accommodate the realities of travel for out-of-office services in that rural area.



In Fiscal Year 2016, the State operated two ICM teams, a team in Sussex County serving on average 177 individuals and a team in New Castle County that is building in size; during the year, it averaged 90 clients, but in June, 2016 it had increased to 134 clients.

[16] The CRISP teams had been operated by two providers, but they have since been consolidated under one provider, serving the same number of individuals.

In terms of the fidelity of ACT teams to program standards, the State conducts preliminary evaluations of new teams; these are not scored, but are intended to assist them in developing proficiency in the service model. Thereafter, teams are evaluated and scored on TMACT at least annually. As indicated, they establish corrective action plans which are monitored by the DSAMH and may entail outside consultation and training. During the period the Agreement has been in effect, there have been some circumstances in which the State determined that an ACT team was not appropriately meeting fidelity standards, even with corrective actions. In these instances, DSAMH closed the team and transferred responsibility to another provider. While this is unfortunate, it does reflect the State's seriousness in ensuring quality and using data to drive decision-making.

Figure-18 presents TMACT scores for the State's ACT teams from Fiscal Year 2014 through 2016. In some instances, reviews are not reported for Fiscal Year 2016 because they were still in process at the time of the State's final data submission for this report. In addition to the TMACT fidelity measures, which focus heavily on the mechanics of ACT teams, DSAMH also carries out extensive outcome measures of its ACT and ICM programs. These measures are a part of the State's Quality Assurance and Performance Improvement program, which is discussed later in this report, but they are included in this section because they are elements of DSAMH's performance monitoring of its ACT and ICM teams.

Figures 19 to 31, which follow, will not be discussed in terms of their specific implications, but they are presented here as evidence of the scope of the State's efforts to assure that these critically important services are producing outcomes that are consistent with the requirements of the Agreement and *Olmstead*. It is notable that one provider (NHS) not only performed poorly in terms of fidelity measures, but as is evident in the following figures, also tended to score high on negative performance indicators (e.g., homelessness) and low on positive indicators (e.g., employment). Based upon these data, the State ended that program.

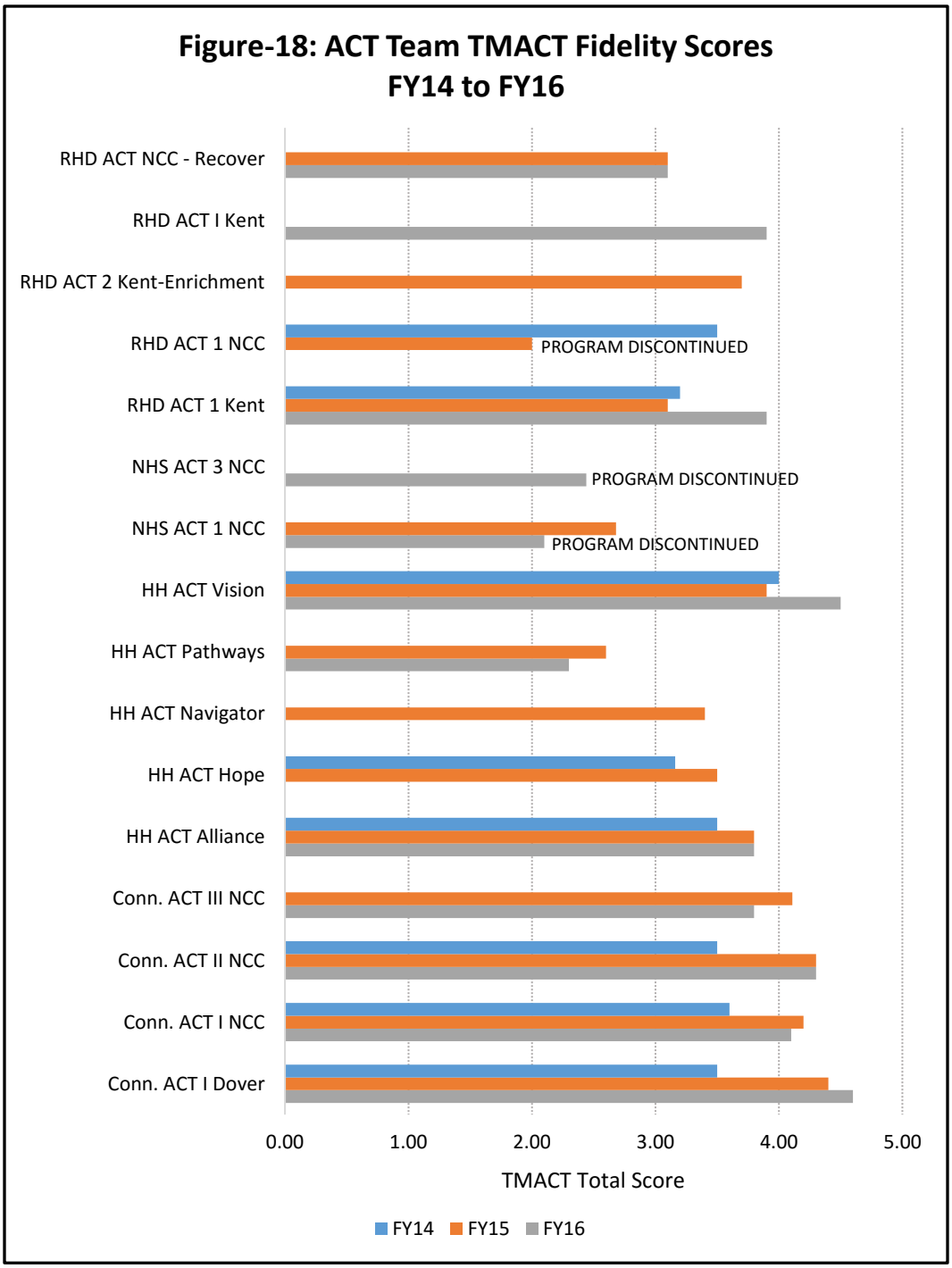
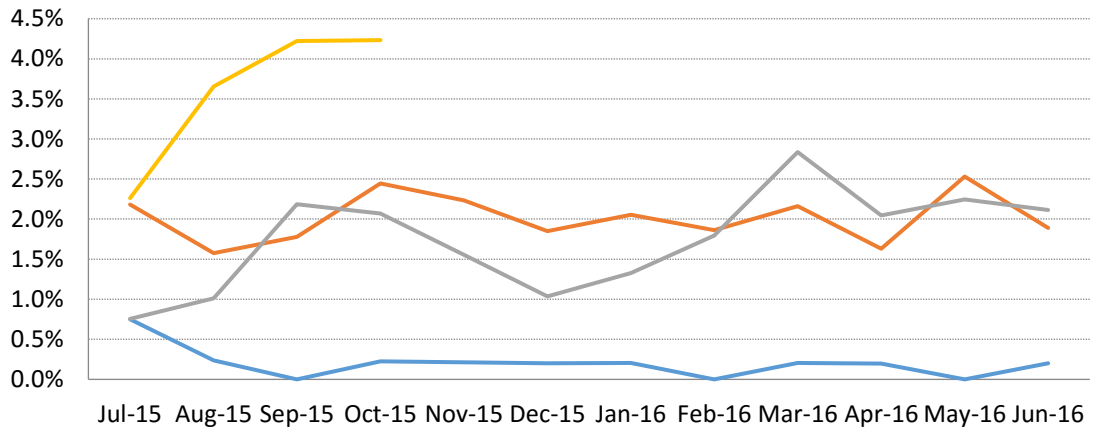


Figure-18: ACT Team TMACT Fidelity Scores
FY14 to FY16
RHD ACT NCC - Recover
RHD ACT I Kent
RHD ACT 2 Kent-Enrichment
RHD ACT 1 NCC
PROGRAM DISCONTINUED
RHD ACT 1 Kent
NHS ACT 3 NCC
PROGRAM DISCONTINUED
NHS ACT 1 NCC
PROGRAM DISCONTINUED
HH ACT Vision
HH ACT Pathways
HH ACT Navigator
HH ACT Hope
HH ACT Alliance
Conn. ACT III NCC
Conn. ACT II NCC
Conn. ACT I NCC
Conn. ACT I Dover
0.00
1.00
2.00
3.00
4.00
5.00
TMACT Total Score
FY14
FY15
FY16

699

Figure-19: ACT/ICM Providers
Average homeless for any night during the month

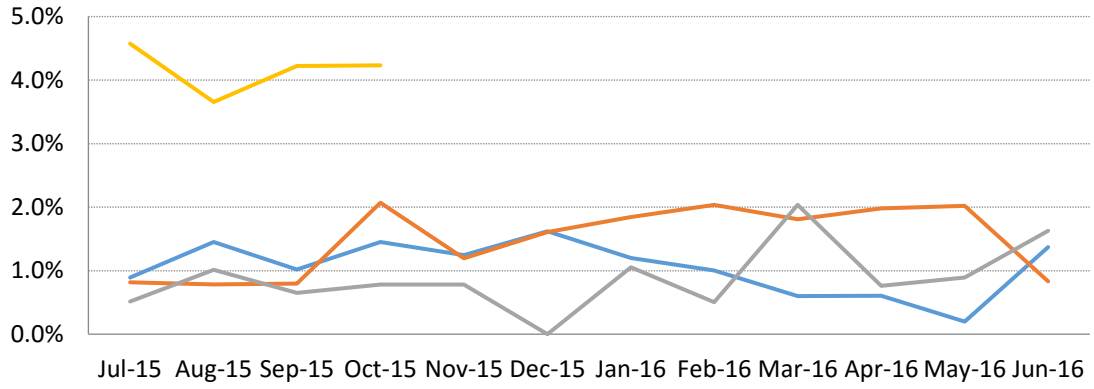


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	0.75%	0.24%	0.00%	0.22%	0.22%	0.20%	0.21%	0.00%	0.21%	0.20%	0.00%	0.20%
HH	2.18%	1.58%	1.78%	2.44%	2.23%	1.85%	2.05%	1.86%	2.16%	1.63%	2.53%	1.89%
RHD	0.76%	1.01%	2.18%	2.07%	1.55%	1.04%	1.33%	1.79%	2.84%	2.05%	2.25%	2.11%
NHS	2.26%	3.65%	4.22%	4.23%								

700

[17]

Figure-20: ACT/ICM Providers
Average Consumers who spent at least one night in a motel during the month

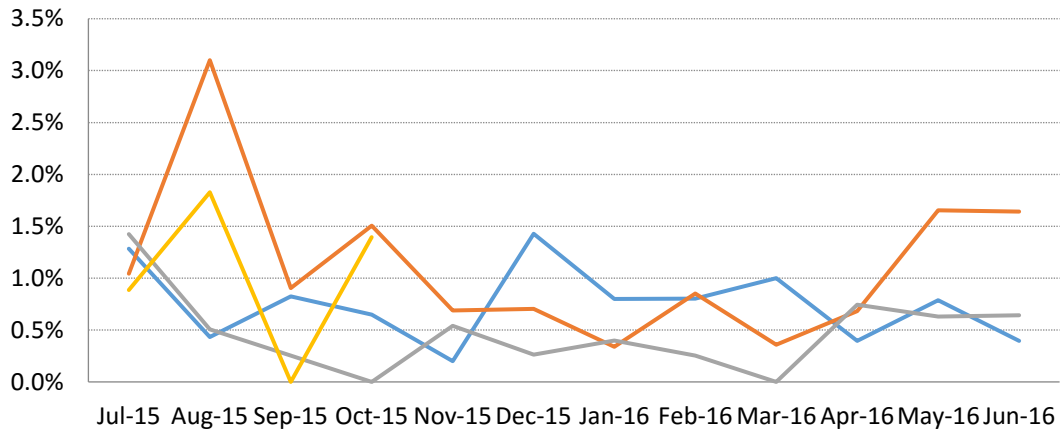


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	0.89%	1.45%	1.02%	1.45%	1.25%	1.62%	1.20%	1.00%	0.60%	0.61%	0.20%	1.37%
HH	0.82%	0.78%	0.79%	2.07%	1.19%	1.61%	1.85%	2.04%	1.81%	1.98%	2.02%	0.83%
RHD	0.51%	1.01%	0.65%	0.78%	0.78%	0.00%	1.05%	0.51%	2.04%	0.76%	0.89%	1.63%
NHS	4.57%	3.65%	4.22%	4.23%								

701

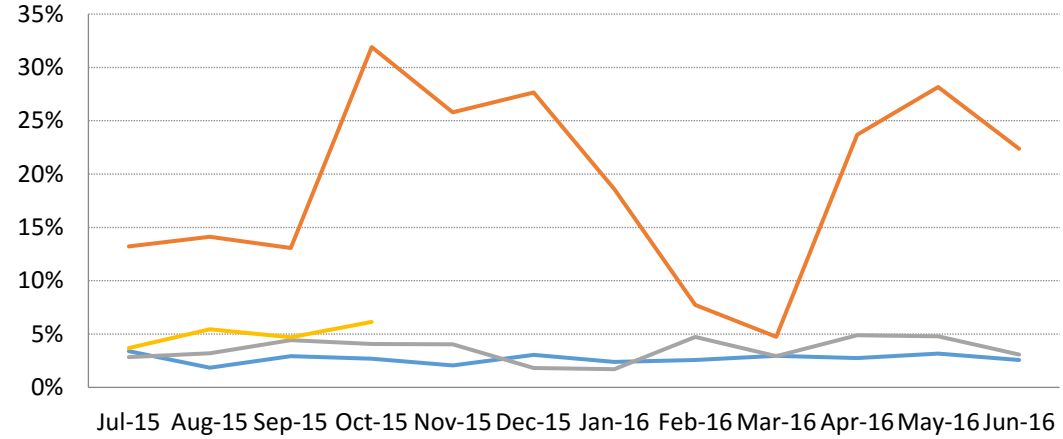
[17] In this, and in the following 12 charts, NHS data is presented through October, 2015, at which point the program was discontinued and clients were transferred to other providers.

Figure-21: ACT/ICM Providers
Average of Consumers arrested



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	1.28%	0.43%	0.82%	0.65%	0.20%	1.43%	0.80%	0.80%	1.00%	0.40%	0.79%	0.39%
HH	1.04%	3.10%	0.90%	1.51%	0.69%	0.70%	0.34%	0.85%	0.36%	0.68%	1.65%	1.64%
RHD	1.42%	0.51%	0.26%	0.00%	0.54%	0.26%	0.40%	0.25%	0.00%	0.74%	0.63%	0.64%
NHS	0.88%	1.83%	0.00%	1.39%								

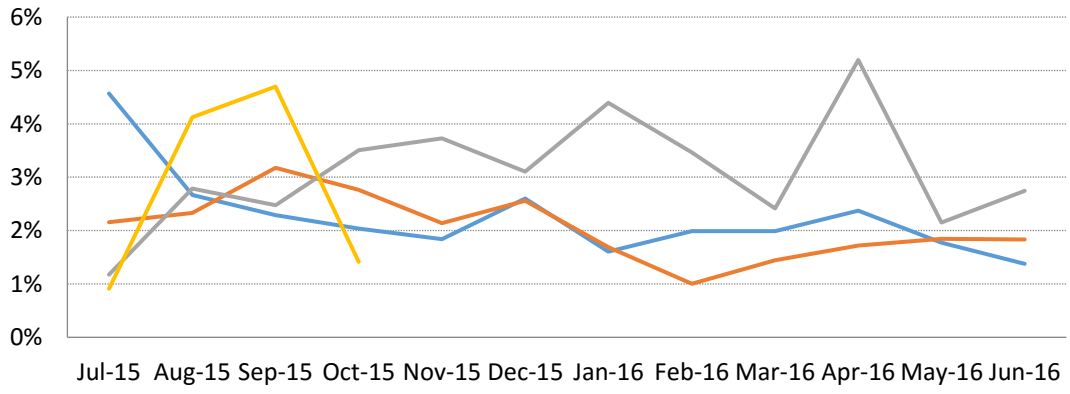
Figure-22: ACT/ICM Providers
Average of Consumers hospitalized in Psychiatric Hospital



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	3.39%	1.85%	2.92%	2.69%	2.06%	3.04%	2.40%	2.56%	2.97%	2.75%	3.17%	2.57%
HH	13.21%	14.13%	13.08%	31.91%	25.79%	27.64%	18.59%	7.74%	4.74%	23.70%	28.17%	22.36%
RHD	2.83%	3.20%	4.42%	4.08%	4.05%	1.83%	1.71%	4.72%	2.94%	4.89%	4.78%	3.09%
NHS	3.69%	5.46%	4.70%	6.14%								

704

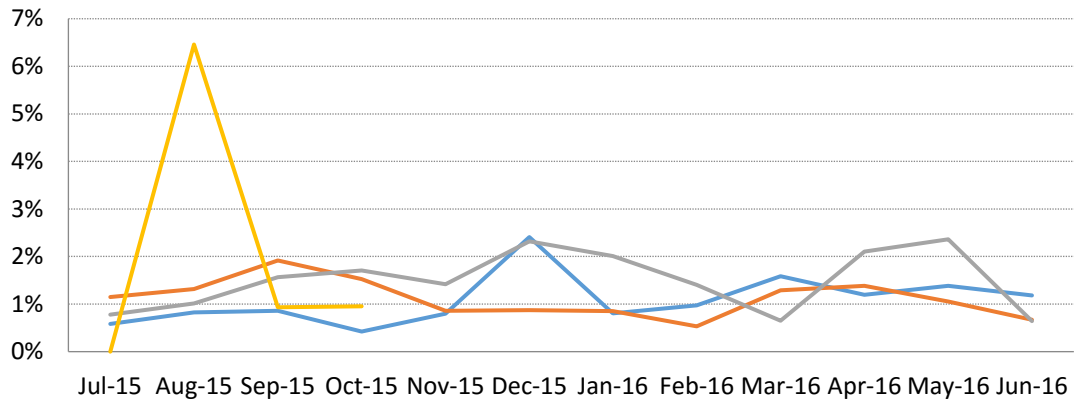
Figure-24: ACT/ICM Providers
Average of Emergency Department Visits



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	4.57%	2.67%	2.29%	2.04%	1.84%	2.60%	1.60%	1.99%	1.99%	2.38%	1.77%	1.38%
HH	2.16%	2.33%	3.18%	2.76%	2.14%	2.56%	1.69%	1.00%	1.45%	1.72%	1.84%	1.83%
RHD	1.17%	2.79%	2.48%	3.50%	3.73%	3.10%	4.39%	3.47%	2.42%	5.20%	2.15%	2.75%
NHS	0.91%	4.12%	4.70%	1.41%								

705

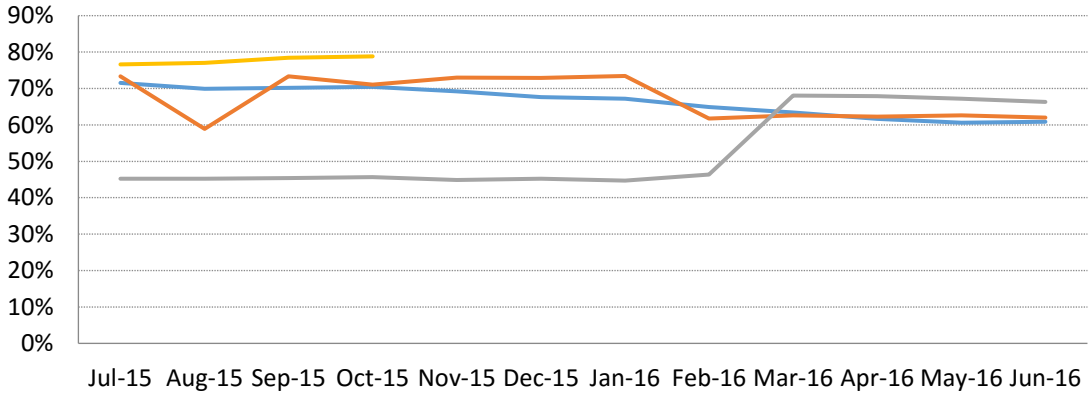
Figure-25: ACT/ICM Providers
Average Consumers admitted to a general hospital



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	0.58%	0.82%	0.86%	0.42%	0.80%	2.41%	0.81%	0.97%	1.59%	1.20%	1.38%	1.18%
HH	1.15%	1.31%	1.92%	1.53%	0.86%	0.87%	0.85%	0.53%	1.29%	1.38%	1.05%	0.67%
RHD	0.78%	1.02%	1.57%	1.71%	1.42%	2.32%	2.01%	1.40%	0.65%	2.10%	2.36%	0.64%
NHS	0.00%	6.46%	0.93%	0.95%								

706

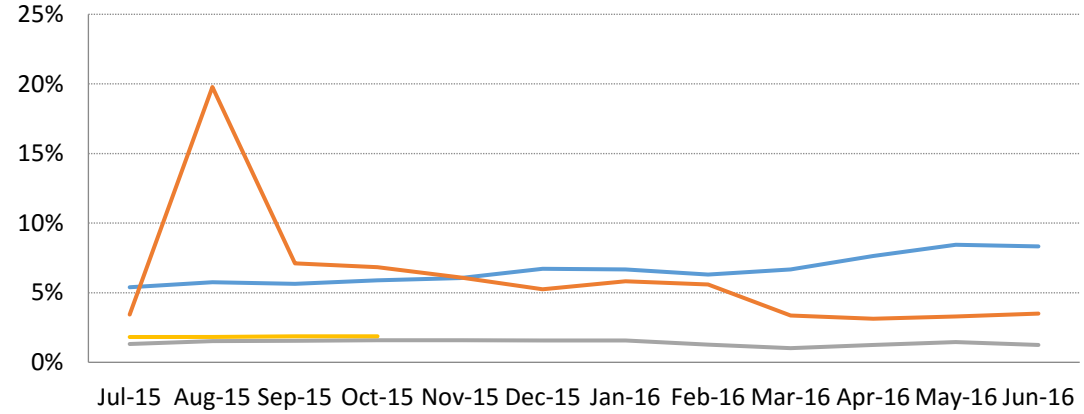
Figure-26: ACT/ICM Providers
Average Consumers unemployed for any period during the month



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	71.53%	69.96%	70.22%	70.46%	69.17%	67.62%	67.15%	64.92%	63.43%	61.69%	60.60%	60.85%
HH	73.30%	58.90%	73.30%	71.09%	72.96%	72.89%	73.44%	61.71%	62.60%	62.28%	62.59%	62.02%
RHD	45.23%	45.22%	45.39%	45.63%	44.85%	45.26%	44.70%	46.40%	68.05%	67.88%	67.17%	66.31%
NHS	76.61%	76.99%	78.42%	78.82%								

707

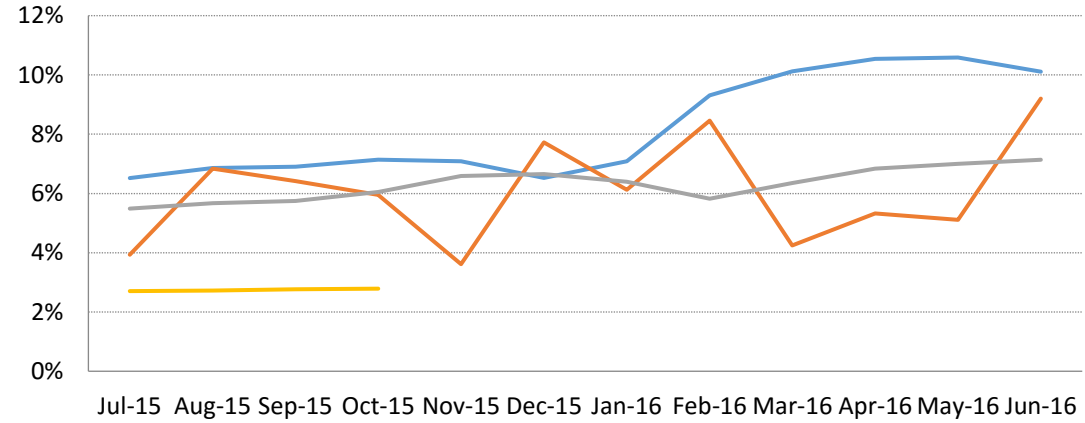
Figure-27: ACT/ICM Providers Average Consumers competitively employed <10 hrs./week:



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	5.39%	5.75%	5.65%	5.88%	6.05%	6.71%	6.66%	6.30%	6.67%	7.64%	8.45%	8.32%
HH	3.44%	19.78%	7.11%	6.84%	6.11%	5.24%	5.82%	5.59%	3.36%	3.13%	3.28%	3.49%
RHD	1.32%	1.53%	1.56%	1.59%	1.59%	1.58%	1.56%	1.26%	1.02%	1.26%	1.47%	1.24%
NHS	1.82%	1.83%	1.86%	1.87%								

708

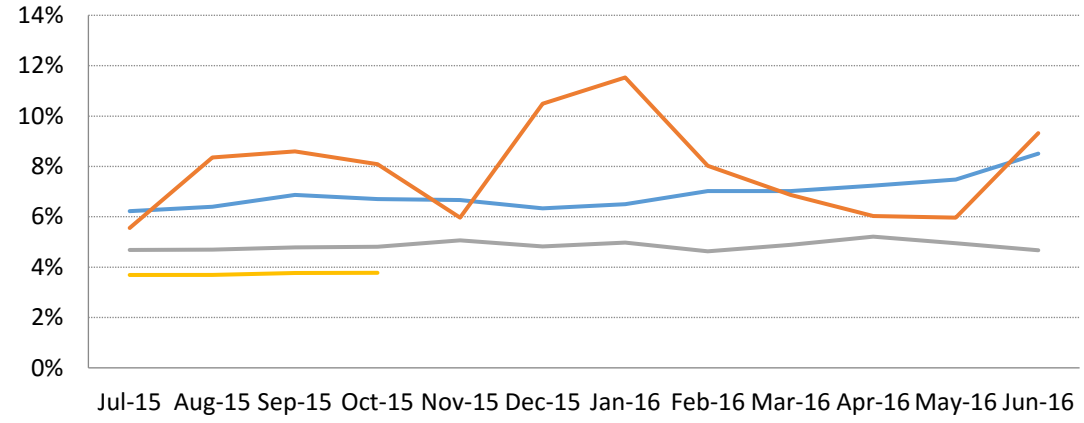
Figure-28: ACT/ICM Providers Average Consumers competitively employed 10-20 hrs./week



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	6.52%	6.86%	6.91%	7.14%	7.09%	6.52%	7.08%	9.31%	10.12%	10.54%	10.59%	10.11%
HH	3.94%	6.84%	6.41%	5.96%	3.61%	7.73%	6.13%	8.46%	4.24%	5.33%	5.11%	9.20%
RHD	5.49%	5.67%	5.75%	6.04%	6.59%	6.65%	6.40%	5.82%	6.36%	6.83%	7.00%	7.14%
NHS	2.70%	2.72%	2.77%	2.79%								

709

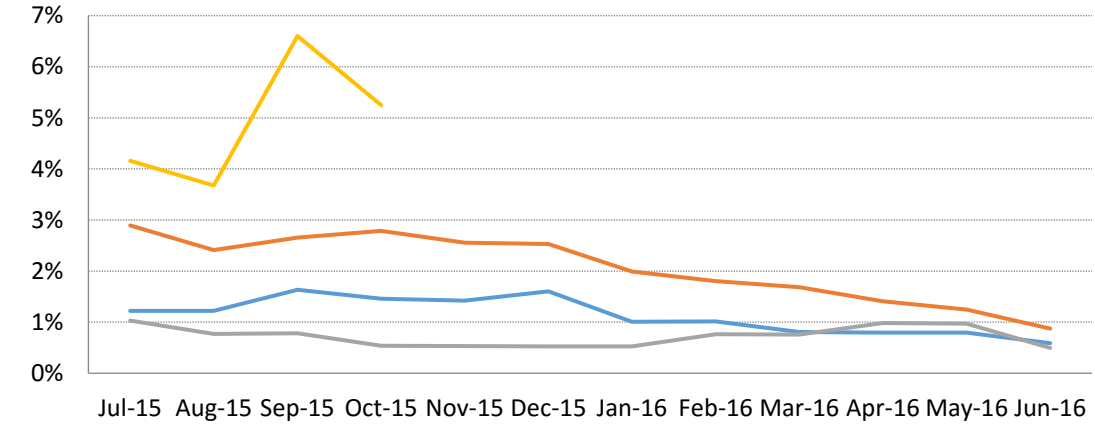
Figure-29: ACT/ICM Providers
Average of Consumers competitively employed 20+ hrs./week



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	6.22%	6.40%	6.86%	6.70%	6.66%	6.34%	6.50%	7.02%	7.02%	7.23%	7.48%	8.51%
HH	5.55%	8.35%	8.60%	8.08%	5.97%	10.49%	11.53%	8.02%	6.86%	6.03%	5.97%	9.32%
RHD	4.68%	4.70%	4.78%	4.81%	5.06%	4.82%	4.97%	4.63%	4.88%	5.21%	4.95%	4.67%
NHS	3.69%	3.70%	3.77%	3.77%								

710

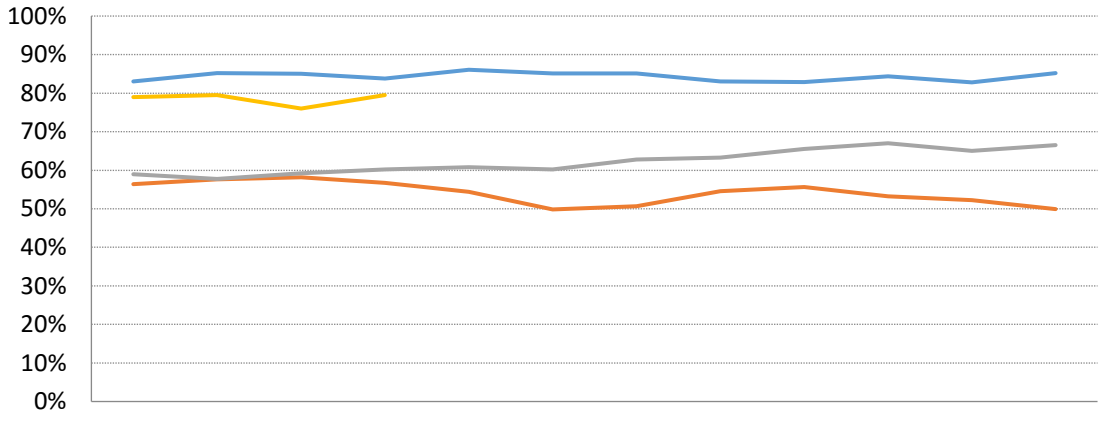
Figure-30: ACT/ICM Providers
Percentage of Consumers on an Outpatient Commitment during the month



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	1.22%	1.22%	1.63%	1.46%	1.42%	1.60%	1.01%	1.02%	0.81%	0.80%	0.80%	0.59%
HH	2.89%	2.41%	2.65%	2.79%	2.55%	2.53%	1.99%	1.81%	1.68%	1.41%	1.24%	0.87%
RHD	1.03%	0.77%	0.78%	0.54%	0.53%	0.53%	0.52%	0.76%	0.76%	0.98%	0.97%	0.50%
NHS	4.16%	3.68%	6.60%	5.25%								

711

Figure-31: ACT/ICM Providers
Percentage of Services provided in the community
(outside the provider's offices)



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Conn	83%	85%	85%	84%	86%	85%	85%	83%	83%	84%	83%	85%
HH	56%	58%	58%	57%	54%	50%	51%	55%	56%	53%	52%	50%
RHD	59%	58%	59%	60%	61%	60%	63%	63%	66%	67%	65%	67%
NHS	79%	80%	76%	80%								

In summary, the State's ACT, ICM, and CRISP programs are important elements of the community service system that enables people with SPM to live in and participate in their communities. In the aggregate, the State is exceeding the Agreement's requirements for the number of such teams and it has in place rigorous and comprehensive systems to monitor and improve performance. It remains in Substantial Compliance with relevant provisions of the Agreement.

VII. Case Management

Substantial Compliance.

Section III.H of the Agreement sets requirements of case management services, which the State refers to as Targeted Care Management (TCM).

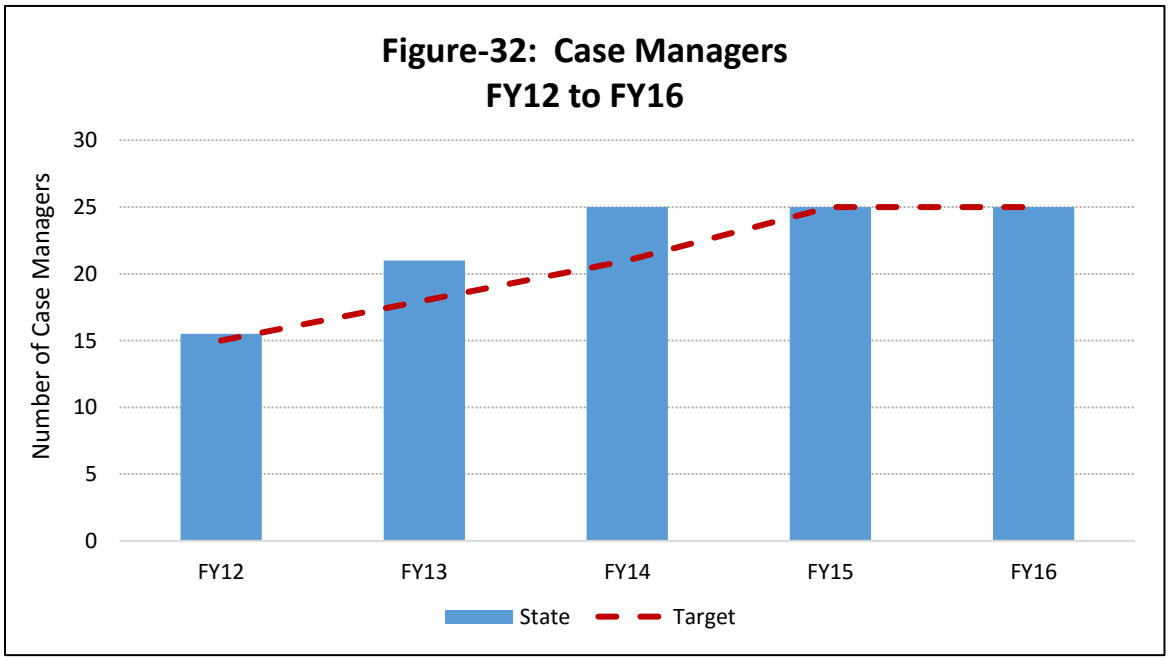
1. By July 1, 2012 the State will train and begin to utilize 15 case managers.

2. By September 1, 2013 the State will train and begin to utilize 3 additional case managers.

3. By September 1, 2014 the State will train and begin to utilize 3 additional case managers.

4. By September 1, 2015 the State will train and begin to utilize 4 additional case managers.

The State has been in Substantial Compliance with these provisions since September, 2013. There are three TCM teams. Two are operated by Recovery Innovations, which also operates the Crisis Walk-In Centers and some of the Crisis Apartment sites. A third team is operated by the State, and has special responsibilities for individuals who are hospitalized at DPC and are not yet engaged with community providers. TCM is a very important service that assists individuals in accessing essential community services. TCM works closely with Mobile Crisis Services in providing follow-up and linkage to ongoing assistance following a mental health emergency. As is referenced elsewhere in this report, TCM assists individuals who have been admitted to IMDs in qualifying for PROMISE services. And TCM plays an important role in assisting individuals who have been identified as homeless via the initiative at the IMDs discussed earlier and in helping them to secure appropriate housing and other



supports. Figure-32 presents the State's history of meeting (and in some years, exceeding) the targets delineated in the Agreement.

Section II.D.2.c.ii limits the number of individuals served by case managers to no more than 35, however, the State has found that the level of need of individuals being served requires more intensive involvement than this would allow. Table-5 presents data on the number of case managers, the average number of individuals served at any point in time, as well as the average clients per case manager.

Table-5: Targeted Care Managers and Point-in-Time Averages of Individuals Served FY 14-16

		FY14 Avg	FY15 Avg	FY16 Avg
State TCM	# of Clients	61.1	58.8	93.3
	# of CMs	5	5	5
	Clients/CM	12.2	11.8	18.7
RI - NCC	# of Clients	123.5	107.5	111.4
	# of CMs	9	9	9
	Clients/CM	13.7	11.9	12.4
RI - Ellendale	# of Clients	104.7	119.6	106.7
	# of CMs	11	11	11
	Clients/CM	9.5	10.9	9.7
Totals	# of Clients	289.3	285.9	311.4
	# of CMs	25	25	25
	Clients/CM	11.6	11.4	12.5

The State continues to be in Substantial Compliance with respect to Case Management services.

VIII. Supported Housing

Substantial Compliance.

Section III.I of the Agreement includes provisions with respect to Supported Housing for members of the target population:

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

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

3. By July 1, 2013 the State will provide housing vouchers or subsidies and bridge funding to a total of 450 individuals.

4. By July 1, 2014 the State will provide housing vouchers or subsidies and bridge funding to a total of 550 individuals.

5. By July 1, 2015 the State will provide housing vouchers or subsidies and bridge funding to a total of 650 individuals.

6. By July 1, 2016 the State will provide housing vouchers or subsidies and bridge funding to anyone in the target population who needs such support. For purposes of this provision, the determination of the number of vouchers or subsidies and bridge funding to be provided shall be based on: the number of individuals in the target population who are on the State's waiting list for supported housing; the number of homeless individuals who have a serious persistent mental illness as determined by the 2016 Delaware Homeless Planning Council Point in Time count; and the number of individuals at DPC or IMDs for whom the lack of a stable living situation is a barrier to discharge. In making this determination, 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).

Supported Housing is an extremely important service for individuals with SPMI, who often have extensive histories of institutionalization in hospitals, criminal justice settings, or congregate mental health residential facilities. In addition, a substantial number of these individuals have histories of

homelessness. Supported Housing is directed at not only providing individuals with stable living environments, but also at promoting the community integration that the ADA and *Olmstead* require. Because people with SPMI have a long history of being relegated to living situations such as nursing facilities, group homes, or apartment buildings restricted to residents with disabilities—settings that may be physically located in the community, but that actually perpetuate the segregation of people with SPMI from the community mainstream—the Agreement includes specific standards for new Supported Housing that is truly integrated into the community. Section II.E requires the State to support members of the target population living in their own homes with services that will:

a. Ensure that people with SPMI can live like the rest of Delawareans, in their own homes, including leased apartments, houses or living with their family;
b. Offer people choice regarding where they live and with whom;
c. Provide an array of supportive services that vary according to people's changing needs and promote housing stability.

Section II.E.2.d and 2.e define minimum standards for integration in terms of what has come to be known in Delaware as the "20%/2-Person Rule;" housing created pursuant to the Agreement is required to be scattered-site—meaning that no greater than 20% of the units in an apartment building may be occupied by people known by the State to have a disability, and no greater than two individuals may occupy an apartment and each must have a private bedroom.

Needless to say, the Agreement's Supported Housing standards represent a sea change from mental health systems (in Delaware and nationwide) whereby individuals with SPMI were routinely assigned to placement "slots" based upon the determination of clinical staff. The placements were mostly in settings where residents' daily interactions were generally limited to staff and other individuals with SPMI, where individuals were assigned roommates and reassigned to different bedrooms per the decisions of staff, and were people were offered no choice around such basic issues as when and what to eat and what time to go to bed.

From the outset of Agreement, the State recognized the significance of Supported Housing in terms of the aims and requirements of the ADA and *Olmstead,* and this has been a very strong element of its implementation efforts. The vignettes presented at the beginning of this report document some of the

dramatic life changes that have occurred as a result of the State's Supported Housing work. Not every story has been a success; Supported Housing is a relatively new service in public mental health and many members of the target population have significant and longstanding challenges associated with mental illness, co-occurring substance use, criminal justice involvement, and other social issues. Furthermore, many such individuals have little or no histories in fulfilling the responsibilities of tenancy, and years of institutional care have bred unnecessary dependence in such areas as food preparation and housekeeping. Notwithstanding these challenges, the State has worked diligently and innovatively to develop a successful Supported Housing program that essentially did not exist prior to the Agreement.

The development of its Supported Housing program required more than simply funding rental subsidies and an assortment of in-home community services. It entailed changing the culture of how mental health professionals assess the housing needs of individuals and incorporate those individuals' personal preferences in their service approaches. Section IV.A.1.b (relating to transition planning from hospitals to the community) delineates an important requirement that gets to the heart of this culture change:

> Discharge assessments shall begin with the presumption that with sufficient supports and services, individuals can live in an integrated community setting.

In Delaware and nationwide, individuals with SPMI were routinely evaluated in terms of "levels of care"—essentially assigning them to housing based on a menu of predetermined segregated housing options that vary in the intensity of services they provide, for instance from several levels of specialized group homes to nursing facility care. Commonly, acceptance of the services provided was a prerequisite for entering community housing. The Agreement requires something different; that assessments be based on the individuals' personal goals, and that the services, supports, and specific housing arrangements be designed accordingly. Furthermore, rather than being regarded as occupying "placement slots," the Agreement requires that individuals have tenancy rights and that, with needed support services, they assume the responsibility of being good tenants.

To promote assessments that meet these requirements, in the first year of implementation the State developed the Community Living Questionnaire to structure interviews with individuals about their housing preferences and their perceptions about what services and supports they will need to live

successfully in their preferred living arrangements, and to reconcile these with staff perceptions of the individual's service needs. This was helpful in reorienting both staff and consumers, both groups having been accustomed to the level-of-care model. The Community Living Questionnaire is included in Appendix-B.

In an important effort to make integrated housing the "default" consideration, DSAMH also required that treatment teams prepare written justification when they recommend housing for an individual in a non-integrated setting, i.e., a setting that does not meet the requirements of the "20%/2-Person Rule." These detailed analyses encourage treatment teams to think carefully and critically about utilizing non-integrated housing. Such requests are reviewed by DSAMH to ensure that individuals are being appropriately afforded opportunities to live in Supported Housing. In some instances, teams have requested approval of living arrangements as alternatives for nursing home placements, for instance, approval for three individuals with medical care needs to occupy a first floor apartment with an on-site staff apartment.

For many members of the target population, the Delaware State Housing Authority's (DSHA) State Rental Assistance Program (SRAP) pays rental costs in Supported Housing. SRAP funding for these individuals is administered through a close coordination between the Housing Authority and DSAMH. For hospitalized individuals (and others in special circumstances) with pending SRAP applications, DSAMH has the capacity to provide immediate bridge funding for rent and other costs so that movement into Supported Housing can proceed without delay.

Prior to individuals moving into Supported Housing, DSAMH conducts an inspection to ensure that it meets basic quality standards and it also completes a DSAMH Integrated Community Certification to affirm that the scattered-site requirements of the Agreement are met or, if not, that a waiver of this requirement has been approved, as discussed above. Such certifications are also used by DSAMH to maintain data about apartment complexes that have reached the 20% limit of tenants known to have disabilities, as well as those that are available to members of the target population without a need for special approval based upon this limit not having been reached. In addition, to help broaden the choices available when providers and clients are exploring housing options, DSAMH housing staff reaches out

to landlords to inform them about the SRAP program and the scope of services that are available to assist individuals to be successful tenants.

DSAMH and DSHA have conducted several landlord outreach meetings, including reaching out to state and local landlord associations. In addition, DSAMH developed a brochure on housing supports for case managers to share with their clients and potential landlords. The State has in place programs to train key stakeholders in the availability of SRAP supports and how to access this resources. These programs have included group trainings by DSAMH and DSHA staff, as well as more individualized consultations with peer specialists, ACT teams, and other providers.

Figure-33 presents data on the number of rental supports (through SRAP and other sources) that the State has funded for the target population for Fiscal Years 2012 through 2016, as well as the targets required per the provisions of Section III.J. The Figure shows that, with the exception of Fiscal Year 2012, the State has exceeded the requirements of the Agreement for each year of implementation (targets are shown in italics; the number of rental supports funded is shown in bold).

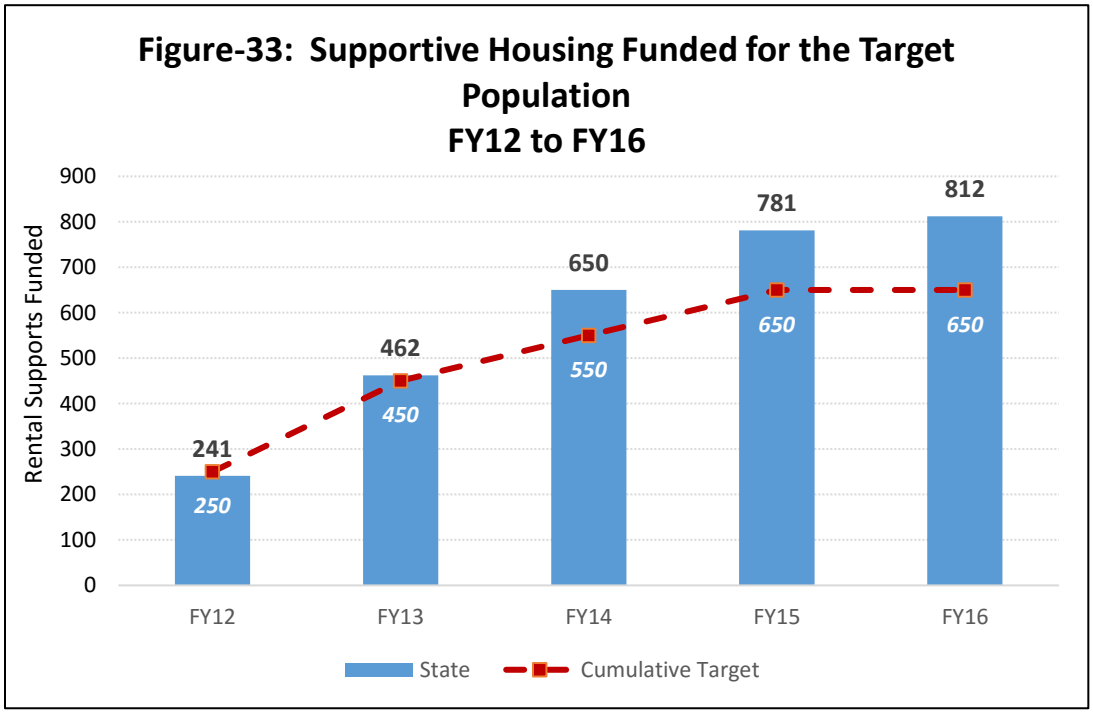
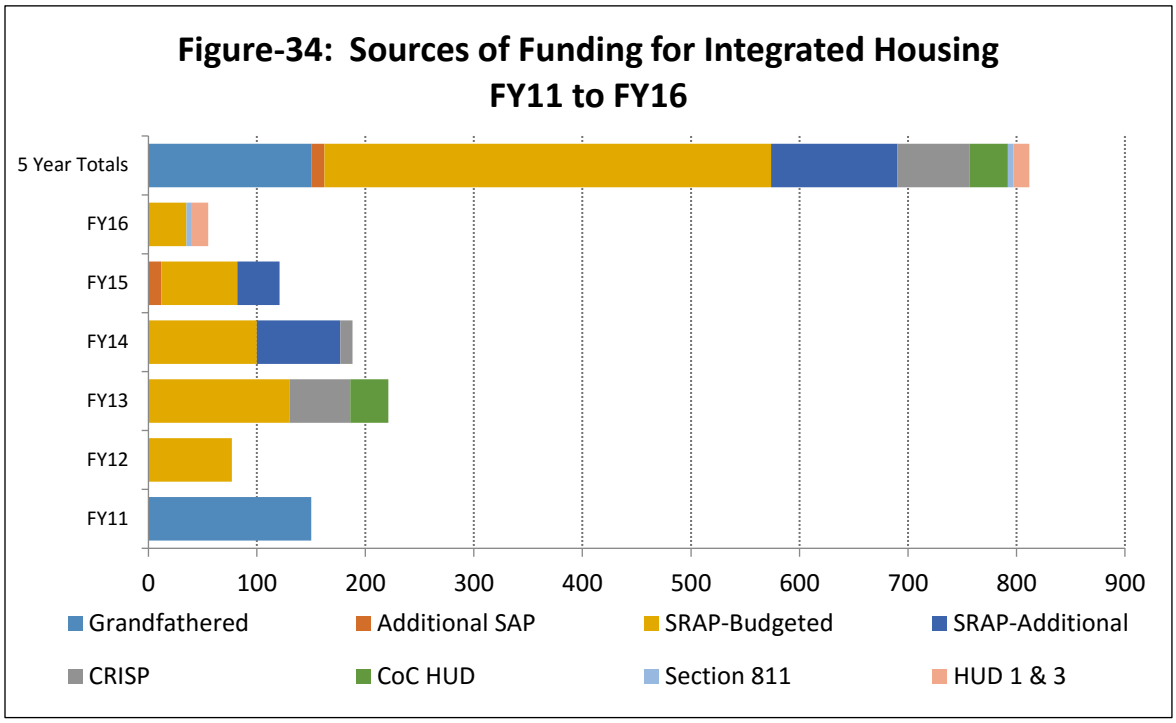


Figure-34 presents the breakdown of how these housing supports were funded for each fiscal year, and for the 5-year overall total. The "Grandfathered" figure relates to Section III.I.1, while the remaining

funding sources reflect a combination of State funds (e.g., SRAP and CRISP) and federal dollars (e.g., HUD).



In Fiscal Year 2016, the State had funding available for 812 individuals. But in practice, the number of housing supports funded for a year does not equal the number of individuals in Supported Housing at any point in time. For instance, most individuals in the Supported Housing program are successful, but some do not succeed as tenants (most often due to substance use and attendant issues). Others leave their apartments for other living arrangements. There are also instances where individuals with rental vouchers through SRAP transfer to federally funded voucher programs. Vouchers that become unused in these ways are "backfilled." And to ensure that vouchers are available throughout the fiscal year (particularly for individuals being discharged from hospitals), the State intentionally does not release all vouchers at the beginning of the year. For all of these—and other—reasons, voucher use is complex and fluid. As of July 1, 2016, for instance, the State had funded up to 528 SRAP vouchers and 461 had been issued. 40 individuals with vouchers were actively looking for apartments and 15 SRAP applications were in process.

Table-6: SRAP Applications and Prioritization of the Waiting List

Group	Definition	Total Applications Received 9/2011 – 5/2016	On Waiting List as of 5/31/16	Percent of Total on Waiting List
HIGHEST PRIORITY				
1	Clients exiting DPC, IMD's and DSAMH's Supervised Apartment Program (clients living in SAP housing who can move to more independent housing are included in this category) and who have a diagnosis of SPMI	259	0	27.8%
2	Clients who have been hospitalized within the last two years (*24 mos.*) and are eligible for or receiving services from an ACT/ICM team and have a diagnosis of SPMI	164	7	
3	Clients from IMDs, ACT/ICM teams (and/or receiving State-funded services such as Medicaid) that meet the federal definition of chronically homeless and have a diagnosis of SPMI.	183	4	
4	Clients receiving services from a DSAMH-funded community mental health program (who are not enrolled in ACT or ICM services and who meet the definition of chronic homeless and have a diagnosis of SPMI).	94	44	
MEDIUM PRIORITY				
5	Clients receiving services from a DSAMH-funded community mental health program such as (TASC, ACT and CMHCs) and who have a diagnosis of SPMI	444	110	55.6%
LOWER PRIORITY				
6	Clients receiving services from a community mental health provider that is not receiving funds from DSAMH.	46	20	16.7%
7	Clients from a Community Service Provider that is not receiving funds from DSAMH	22	13	
TOTAL	**Remains on Waiting List**	**1212**	**198**	**16.3%**

891

Table-6 presents the State's approach to prioritizing members of the target population for rental supports, as well as the number of applications received from September, 2011, through the end of May, 2016, and the number of individuals on a waiting list for housing supports as of the end of May, 2016. Highest priority is afforded individuals in DPC, an IMD, or the Supervised Apartment Program (the intent with regard to Supervised Apartments is to free up those beds for other high-risk individuals), for those recently hospitalized and in need on intensive services (i.e., ACT/ICM), and those who are homeless. These individuals account for 27.8% of the housing waiting list and they tend to remain on the waiting list only briefly. Among them, no individuals exiting hospitals or the supervised apartments (Group 1) were on the waiting list as of the date shown. Other individuals in the highest priority categories are homeless or are living in unstable housing. Individuals in Groups 5-7 account for 72.2% of the individuals on the waiting list. They are assigned lower levels of priority because they have stable housing and are not in hospitals, but their housing may not be integrated.

Section III.I.6 of the Agreement is lengthy, but it essentially requires the State to be able to demonstrate that its Supported Housing program not only meets the targets established in Sections III.I.1-5, but also that it makes reasonable efforts to expand its housing program to accommodate the needs of the target population, particularly hospitalized or homeless individuals. Table-7 summarizes the State's data with respect to subgroups of the target population that are referenced in this Section. As many as 232 individuals who may be covered by the Agreement meet one or more of the factors identified in Section III.I.6. The largest group—132 individuals counted in the Delaware Homeless Planning Council in its Point in Time study—is based upon a one-night snapshot of individuals in shelters, those who are unsheltered, and other sources. This study does not collect individuals' names, so it is unknown if some of the individuals counted are already being served by DSAMH, and it is possible that they may be counted in other categories within this table. Furthermore, their mental health status is based upon self-report and whether they meet criteria for SPMI is not known. As such, this category is a very blunt measure of need with respect to the Agreement. As is discussed elsewhere in this report, though, if these individuals come to be psychiatrically hospitalized, or if they come into contact with DSAMH programs, they will be referred for housing evaluations. With respect to the other categories presented in the table, the discussion above describes the State's prioritization of high-risk individuals for housing

supports. And individuals awaiting discharge from DPC because of housing issues[18] are not awaiting supported housing, but rather have special needs (particularly medical needs).

Table-7: Estimates of Housing Needs per Section III.I.6 of the Agreement

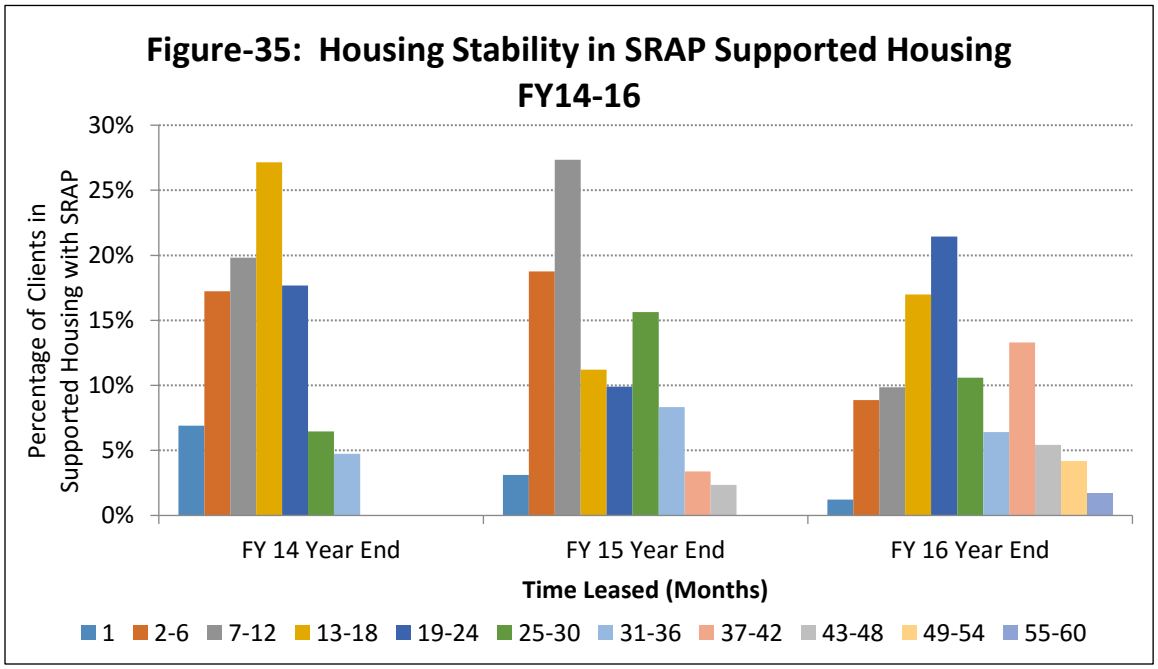
(Individuals counted by the Homeless Planning Council may be duplicated in other categories)

The number of individuals in the target population who are on the State's waiting list for supportive housing as of 5.31.16		48
The number of homeless individuals with severe mental illness as determined by the 2016 Delaware Homeless Planning Council in the Point in Time count		132
Total number of individuals at DPC or IMD's whom for the lack of a stable living situation is a barrier to discharge, as of 6.15.16		52
Awaiting Supported Housing or Supervised Apartment	0	
Awaiting ACT or CRISP services	16	
Awaiting Group Home or Nursing Facility	26	
Awaiting resolution of legal issues	6	
Discharge imminent	4	
Total		232

Figure-35 presents data on the length of tenancy of the target population in Supported Housing and how the distribution of tenancy has changed between Fiscal Year 2014 and 2016. In 2014, individuals had been tenants in Supported Housing from one month to 36 months, with the highest category of tenancy being from 13-18 months (27%). By 2016, the distribution had changed significantly; tenancy ranged from one month to five years (60 months), and the category into which individuals most frequently fell into was longer (19-24 months). In other words, notwithstanding the "churning" referenced above, whereby some individuals are unsuccessful as tenants or otherwise leave supported housing, the overall profile of the State's Supported Housing program is that individuals are remaining permanently housed

[18] The number of such individuals at IMDs is small, if any. They would either be referred to TCM or, if clinically unstable, transferred to DPC.

for longer periods of time. Whereas in 2014, 11.2% of the target population receiving SRAP support had lived in their apartments for two years or longer, by 2016, that proportion had increased to 41.6%.



Monitor reports have rated the State to be in Substantial Compliance with the Agreement's Supported Housing requirements since September, 2012, and it remains so. The State has developed an impressive program that has not only met the annual targets of the Agreement's provisions,[19] but it has also changed the service culture for individuals who have SPMI and with respect to the requirements of *Olmstead*.

In regard to needs beyond what is required in Section III.I.1-5 (i.e., the requirements of Section III.I.6), the State has already significantly exceeded the Agreement's numerical targets for housing vouchers. Furthermore, it has in place effective mechanisms to connect members of the target population with housing, for instance for homeless individuals who are hospitalized at DPC or an IMD. As is discussed in this, as well as prior Monitor reports, Supported Housing is a critical factor in achieving community integration for individuals who have SPMI and it is among the strongest elements of the State's implementation efforts.

[19] 2012 showed a minor deviation from that year's target.

IX. Supported Employment

Substantial Compliance.

Section III.J of the Agreement includes provisions relating to Supported Employment services to the target population.

1. By July 1, 2012 the State will provide supported employment to 100 individuals per year.
2. By July 1, 2013 the State will provide supported employment to 300 additional individuals per year.
3. By July 1, 2014 the State will provide supported employment to an additional 300 individuals per year.
4. By July 1, 2015 the State will provide supported employment to an additional 400 individuals per year.
5. In addition, by January 1, 2012 all individuals receiving ACT services will receive support from employment specialists on their ACT teams.

Like Supported Housing, Supported Employment is a critically important service with respect to *Olmstead* compliance in that it is specifically directed at enabling individuals with SPMI to participate in the community mainstream. Employment is not only a means of achieving self-sufficiency, but it is also an important aspect of an adult's social identity and role in the community. Historically, people with SPMI have been excluded from the workforce or relegated to "sheltered" work programs that segregate people with disabilities. Following hospitalization, many such individuals were assigned the identity of "former mental patient" by the community. Supported Employment changes that. It allows people with SPMI to pursue their personal employment goals and to hold competitive, ordinary jobs alongside people who do not have disabilities.

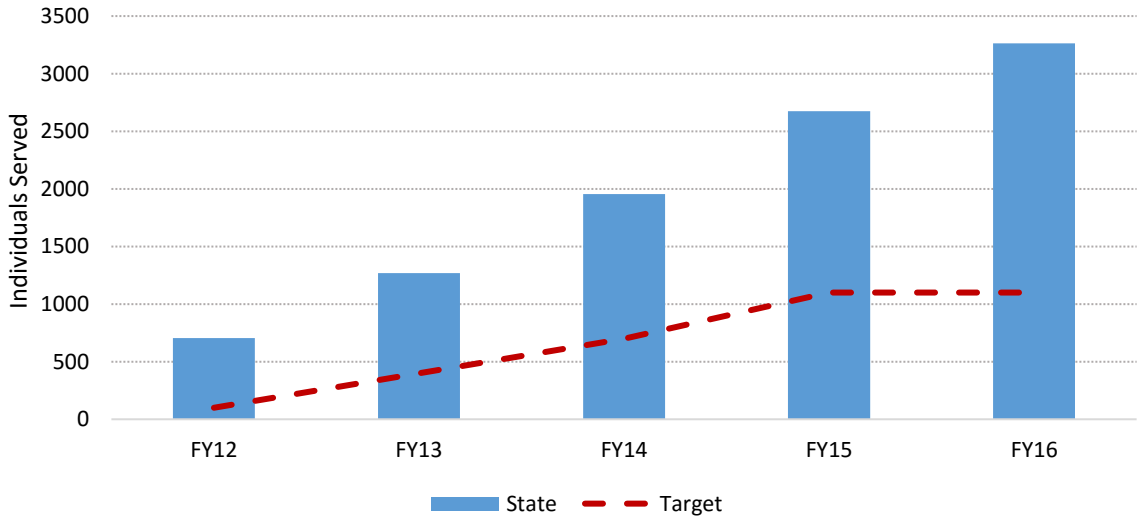
The State's Division of Vocational Rehabilitation (DVR) has a long history of close collaboration with DSAMH to promote mainstream employment for people with SPMI. A part of this collaboration has been to support ACT teams in assisting the individuals they serve in entering the workforce. Nationwide, vocational rehabilitation services that receive federal funding (as does DVR) have limitations in providing ongoing services to individuals once they secure employment. Recognizing that

individuals with SPMI often require employment services that extend beyond these limits, the State's PROMISE program includes Medicaid coverage of Short-Term Small Group Supported Employment and ongoing Individual Employment Supports. As PROMISE becomes more fully operational, these employment services have the potential to significantly increase the number of individuals in the target population entering the mainstream workforce, as well as the number that approach or reach full-time employment.

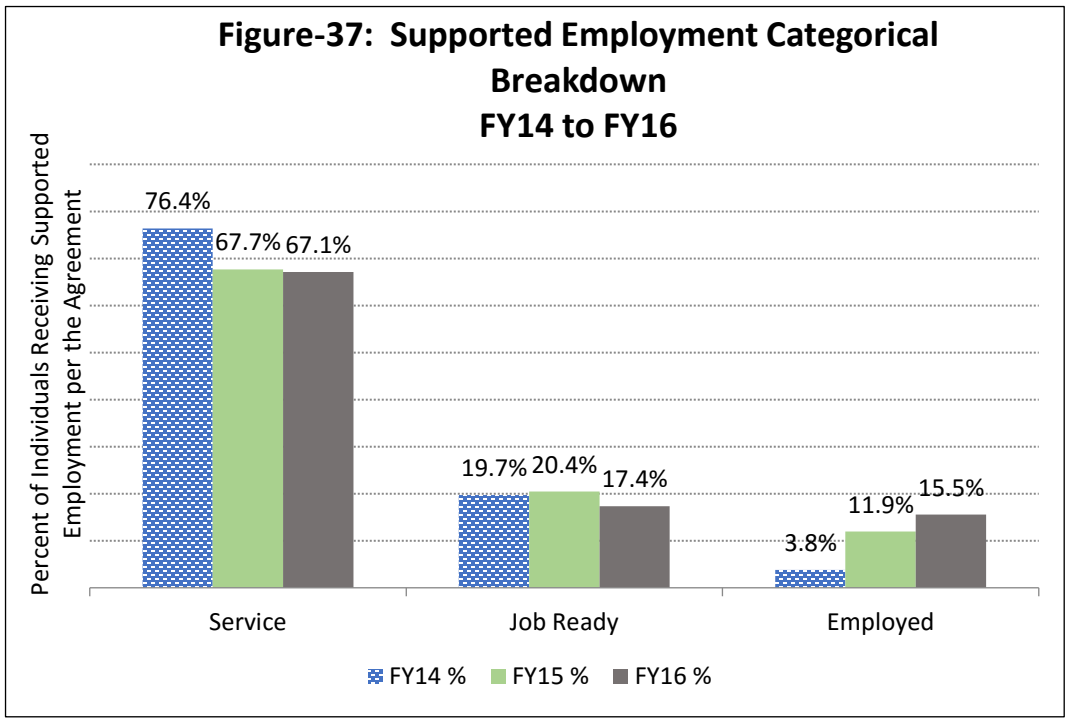
The State has been rated as being in Substantial Compliance with the Agreement's Supported Employment requirements since September, 2012 and it remains so. Figure-36 presents the number of individuals within the target population who are receiving Supported Employment services, meaning that they have active employment plans or are at some level of service beyond this, including to the point of holding a job. As Figure-36 indicates, the State has exceeded the Agreement's numerical targets for each year of implementation.

The target population has special challenges in entering the mainstream workforce. Beyond the employment discrimination that the ADA and other laws seek to overcome, many individuals lack work skills and histories of stable employment. Anecdotally, several individuals who are living in their own apartments following long histories of institutionalization have expressed the feeling to the Monitor that

Figure-36: Members of the Target Population Receiving Supported Employment Services FY12 to FY16



they are not yet ready to pursue employment and that they need to concentrate upon fulfilling the daily demands of maintaining their homes, shopping, and so on. Figure-37 presents data on the movement of members of the target population who are receiving Supported Employment services from initial work on employment plans (such as basic work skills) to job readiness (seeking employment) to actual employment. It shows that there has been a significant increase in the proportion of people who actively employed—about a fourfold increase since Fiscal Year 2014. Furthermore, because the population of individuals receiving supported employment is increasing yearly (per Figure-36), the absolute numbers of individuals represented by these proportions is increasing as well.



X. Rehabilitation Services

Substantial Compliance.

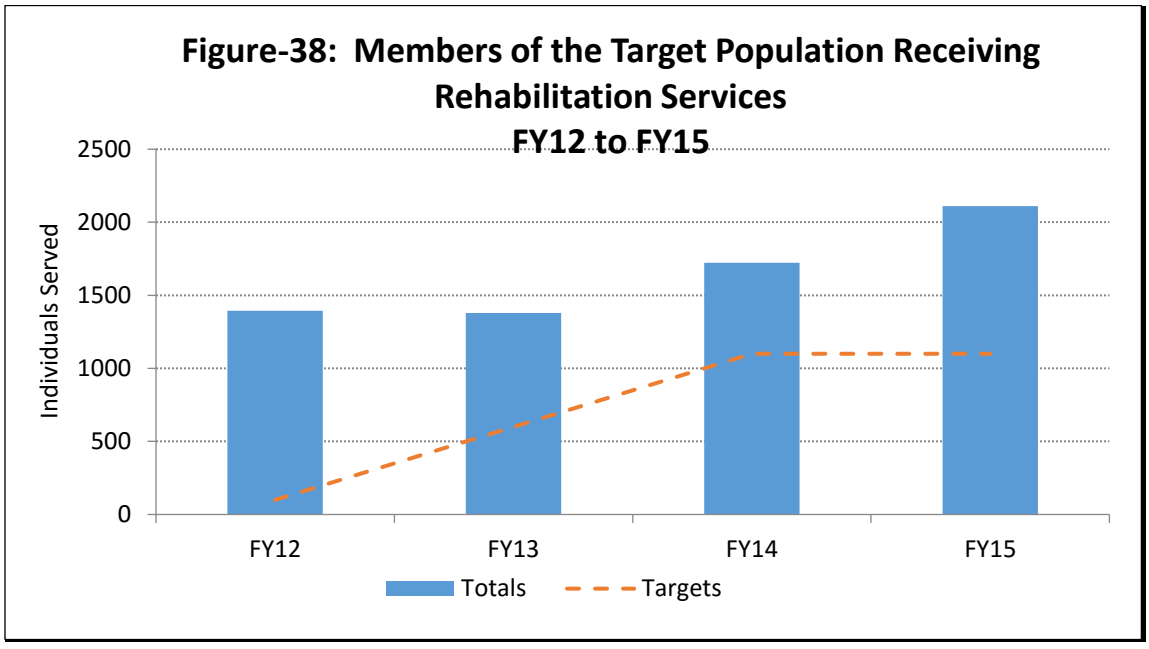
Section III.K of the Agreement includes requirements for Rehabilitation Services:

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

2. By July 1, 2013 the State will provide rehabilitation services to 500 additional individuals per year.
3. By July 1, 2014 the State will provide rehabilitation services to an additional 500 individuals per year.

Rehabilitation Services include a broad array of activities, such as education, substance use disorder treatment, recreation, training in functional skills, and other activities that promote community integration. Because they are embedded in so many of the services provided under the Agreement, early in the Agreement the parties agreed that Rehabilitation Services would be quantified for purposes of evaluating the State's compliance by counting:

1) Any ACT or ICM client receiving one of the services below at least twice a month in any six months of the fiscal year:
   a) Psycho-Social Rehabilitative Services
   b) Psycho-Social Group Services
   c) Family Psycho-Social Education
2) Any individual on the Target Population Priority List who also appears on DSAMH's substance use treatment database and is thus receiving services for co-occurring substance use problems.



The State has been in Substantial Compliance with the Agreement's Rehabilitation Service requirements since September, 2012 and, as is indicated in Figure-38, it continues to exceed the numerical targets contained in Section III.K.

XI. Family and Peer Supports

Substantial Compliance.

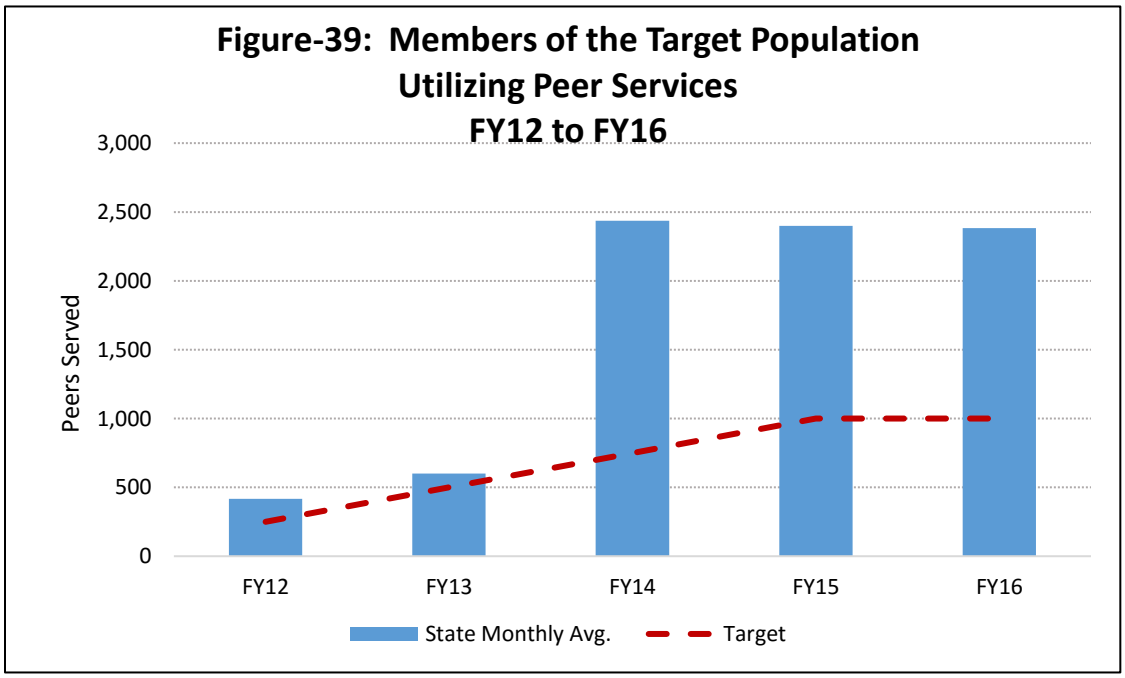
Section III.L of the Agreement includes provisions relating to Family and Peer Supports.

1. By July 1, 2012 the State will provide family or peer supports to 250 individuals per year.
2. By July 1, 2013 the State will provide family or peer supports to 250 additional individuals per year.
3. By July 1, 2014 the State will provide family or peer supports to an additional 250 individuals per year.
4. By July 1, 2015 the State will provide family or peer supports to an additional 250 individuals per year.

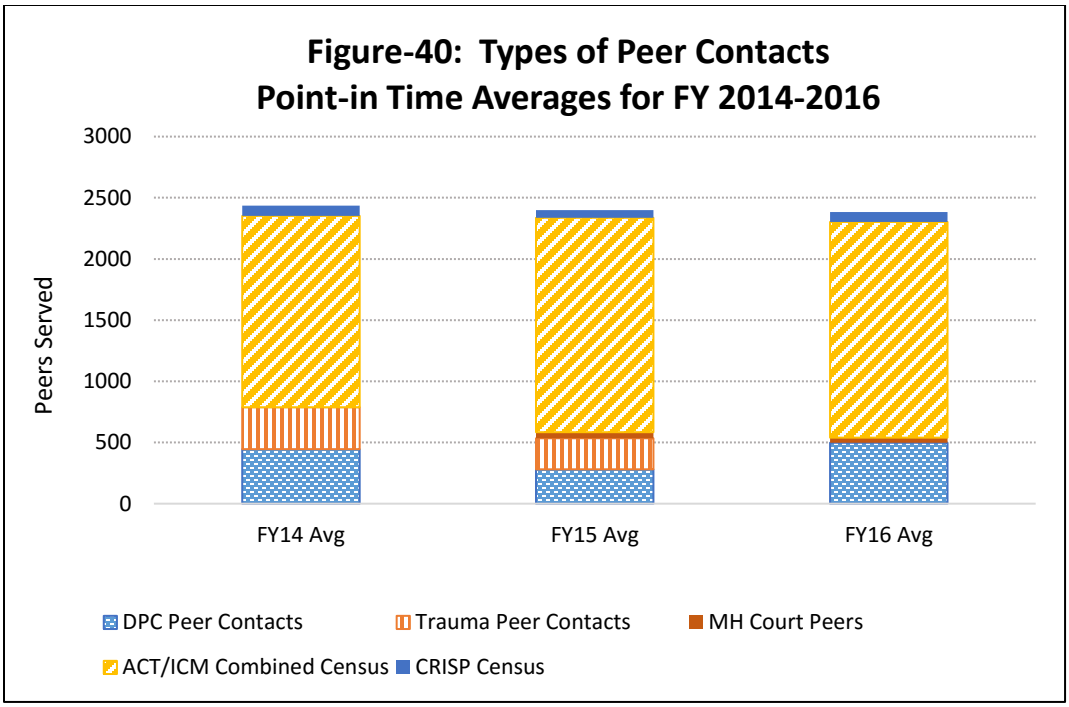
Family Supports entail training and consultation that enable family members to play an active role in individuals' recovery process. Peer Supports are services provided by individuals who, themselves, have mental illness and who have direct experience in recovery and in addressing many of the challenges confronting members of the target population.

The State provides both Family Supports and Peer Supports to the target population, but it maintains the best data with regard to Peer Supports; these data have been included in Monitor reports throughout implementation. Peer services have flourished through the course of the implementation period to the point that what was once a narrow aspect of DSAMH services has now become ubiquitous. Trained peers are embedded as critically important elements of services in ACT, ICM, Crisis Apartments, Crisis Walk-In Centers, and other programs. They play a very significant role in handling consumer complaints. Peers orient individuals upon their admission to DPC, assist them during the course of their hospitalization, and provide tote bags with toiletries and other essentials upon discharge to the

community. Peers operate drop-in centers in the northern and southern parts of the State (the Rick VanStory Center and the ACE Center, respectively), as well as an art gallery (the Creative Vision Factory) in downtown Wilmington featuring the artwork of people with SPMI. Recently, peers helped to create a monument as a part of the restoration of a graveyard that had been used over the decades for patients of DPC. Peers played an important, substantive role in reforming Delaware's mental health laws and will be members of the oversight subcommittee established through Senate Bill 245. Peers have been trained as research assistants who helped to construct and implement the quality reviews of ICM and CRISP services discussed later. Peers conduct certification trainings that enable the services of peer specialists to be reimbursable under the PROMISE program. And, finally, throughout the course of implementation, peer specialists and the people they assist have been invaluable sources of information and education for the Monitor.



In short, Peer Support services and the larger peer movement in Delaware have become a vibrant component of the service system for people with SPMI, and in multiple ways—beyond the requirements of Section III.L, they have helped move the State towards compliance with the Agreement and



Olmstead. Figure-39 demonstrates that, for each year of implementation, the number of individuals receiving Peer Supports has exceeded—and, for the last three years, far exceeded—the Agreement's requirements.

Figure-40 presents a breakdown of the types of peer contacts occurring during the past three years. In 2016, federal funding for an important peer program addressing trauma ended. In 2015, peers began providing mentoring services in the New Castle County mental health court.

In summary, the promotion, systemic integration, and meaningful utilization of peer services is another important accomplishment of the State in implementing the Agreement.

XII. Transition Planning

Section IV.B of the Agreement includes requirements with respect to Transition Planning for members of the target population in DPC or an IMD. The subsection that is currently relevant is as follows:

4. The State shall have as its goal that where a transition team determines that a community placement is the most integrated setting appropriate for an individual currently in DPC or an IMD, that individual will be discharged to the community with necessary supports within 30 days. Between July 1, 2014 and July 1, 2015, the State shall meet this goal for at least 75% of people transitioning from DPC or an IMD. Between July 1, 2015 and July 1, 2016, the State shall meet this goal for at least 95% of people transitioning from DPC or an IMD.

The intent of this provision is that once an individual who is hospitalized has been determined to be ready for discharge, transition arrangements should proceed in a timely way and that individual should be released in less than 30 days with appropriate community services and supports. While this is a straightforward requirement, its meaningful application is less so. As has been discussed earlier, the overwhelming majority of hospitalizations among the target population occur within IMDs, where the length of inpatient care averages fewer than seven days and only about 5% of the discharges exceed 14 days of hospitalization. Thus, for the population receiving Acute Care in IMDs (which, by definition lasts 14 days or fewer) and where MCOs' approvals of benefits tend to be for 6-7 days of hospital care, a standard requiring that once an individual has become clinically stable, discharge occur within 30 days is not very meaningful.

In DPC, it is somewhat of a different story. DPC admits individuals directly from the community for acute care and, while their lengths of stay are a bit longer than in the IMDs, by definition, their discharges occur within 14 days. DPC also accepts transfers from the IMDs of individuals who have complex needs and cannot be stabilized within the Acute Care period; the hospitalizations of these "blended" admissions tend to extend into the Intermediate Care categories, which may last up to 179 days. Other individuals are directly readmitted to DPC when in need of hospital care because they have extensive psychiatric histories; they are known to the facility and tend to require extended inpatient care. Finally, although the State's success in linking this group with intensive community services has reduced their hospitalization rates dramatically, there are still individuals at DPC receiving Long Term Care, which can extend from 180 days to decades. With the exception of the Acute Care group, it is possible that transition arrangements for other patients at DPC (i.e., those receiving Intermediate or

Long Term Care) *could* have exceeded 30 days beyond a determination that hospital care is no longer needed, and it is for this group that the requirements of Section IV.B.4 are most meaningful.

Table-8: Inpatient 30-Day Post-Stabilization Breakdown

	FY15			FY16		
	DPC	**IMD**	**Total**	**DPC**	**IMD**	**Total**
Total Number of Discharges (Acute, Intermediate, and Long Term)	154	2,815	2,969	375	2,554	2,929
Number of Discharges within 30 Days of Psychiatric Stabilization	126	2,807	2,933	303	2,546	2,849
% of Discharges within 30 Days of Psychiatric Stabilization	81.8%	99.7%	98.8%	80.8%	99.7%	97.3%

Table-8 presents data from Fiscal Years 2015 and 2016 on the timeliness of discharge following a determination that hospitalization is no longer needed in DPC, in the IMDs, and in the aggregate. It shows that the State's overall success in these years in discharging individuals within 30 days is 98.8% and 97.3%, respectively.

In DPC, the success rate with respect to the 30-day standard is lower; 81.8% in Fiscal Year 2015 and 80.8% in Fiscal Year 2016. Table-9 provides a snapshot of individuals at DPC awaiting discharge at three points in time. These figures reflect both individuals whose discharges exceed 30 days beyond stabilization and individuals whose discharges are proceeding within this time frame, but they give a sense of the factors that impede transition from the hospital. First of all, the number of individuals reflected in each of the discharge barriers listed is small, fewer than 20. The barriers most frequently occurring relate to Group Home or Nursing Facility waiting lists (these individuals tend to have complex medical issues and would have been exempted from Supported Housing in the process discussed earlier), and to waiting for an opening in ACT or CRISP services. With regard to the latter, DSAMH is aware that this has become a factor delaying discharge from DPC and it is now examining whether individuals are appropriately moving through these programs when they no longer require such intense services. It is working with providers in this regard. DSAMH believes that addressing this issue could significantly help in freeing up services for individuals who remain hospitalized.

Table-9: Point-in-Time Breakdown of Discharge Barriers at DPC						
	FY15 (6/30/15)		FY16 (12/31/15)		FY16 (6/30/16)	
	n	%	n	%	n	%
Number of Clients Ready for Discharge	56		45		52	
Provider Active/Currently Discharging	16	28.6%	11	24.4%	4	7.7%
Group Home List	12	21.4%	8	17.8%	19	36.5%
Nursing Home/DDDS List	8	14.3%	5	11.1%	7	13.5%
Legal Barriers	4	7.1%	3	6.7%	2	3.8%
ACT/CRISP List	2	3.6%	3	6.7%	16	30.8%
Other (Medicaid pending, Level of Care determination, etc.)	14	25.0%	15	33.3%	4	7.7%

In addition to the information presented above, the State maintains extensive additional data that it uses to monitor the timeliness of discharge and the factors that impede individuals' timely return to the community. Although the timeliness measures at DPC do not meet the standard established in Section IV.B.4, relatively small number of individuals—many of whom require medical care services—are affected. Furthermore, the State is taking appropriate actions to address delays that relate to openings in programs such as ACT and CRISP. Finally, when all hospitalizations are considered, including stays at the IMDs that are, by design, of very short duration and very rarely extend to anything near 30 days, the State is meeting the plain language of this provision. For all of these reasons, the State is rated as being in Substantial Compliance with Section IV.B.4.

XIII. Quality Assurance and Performance Improvement

Substantial Compliance.

Section V.A of the Agreement requires that the State have in place a Quality Assurance and Performance Improvement (QA/PI) system that ensures that services are of appropriate quality and that they are achieving the goals of community integration, independence, and self-determination that the

Agreement requires. The extensive data on which this report is based is evidence that the State, indeed, has such a system in place. Furthermore, as was discussed with respect to the State's establishment of a new Crisis Walk-In Center or the discontinuation of some ACT teams, the State uses performance data to make decisions about expanding programs and program contracting. Figures-19 through -31 document that the State monitors the quality of its intensive service programs in terms of such important dimensions as arrest rates, emergency room use, and hours of competitive employment and that it can analyze such outcomes either in the aggregate or on a program or team level.

The Monitor's ninth report, which was issued recently (on 5/26/16) described how the State has greatly increased the coordination of its QA/PI activities, in part by establishing the Quality Control Steering Committee to serve as the hub of analysis and identification of new initiatives. That report summarized an array of ongoing QA/PI activities that are relevant to the Agreement:

1. A Quality Process Review of ACT and ICM that has been ongoing since 2015 (Figures-19 through -31).
2. An investigation, which was initiated in 2015, of how homelessness affected lengths of stay among members of the target population who were hospitalized at DPC.
3. A study of rates of court commitment for inpatient or outpatient treatment, which shows the systems impressive move towards voluntary treatment (Discussed below, see Figure-48).
4. Monthly QA meetings between DSAMH and the IMDs to resolve problems in care, including coordination and information sharing between hospital and community providers
5. An investigation of the needs of individuals living in community housing who have complex challenges, particularly with respect to addressing Activities of Daily Living. This program was initiated in 2015.
6. A Client Death Review investigation focusing on deaths occurring outside of hospital settings. This study is a component of DSAMH's risk management activities.

7. An initiative to incorporate into practice data from the evaluation of DSAMH's CRISP program that reflects the ongoing partnership between the State and the University of Pennsylvania.

Some of the initiatives cited above will be discussed more fully in the section below relating to QA/PI activities relating to the new Crisis Stabilization measures. As an example of a QA/PI initiative that does not relate to these measures, the CRISP initiative (#7 above) is a longitudinal project that is now at the point where the State can analyze data on individuals with SPMI who had been hospitalized at DPC for protracted periods of time and who are now living in integrated settings with support services pursuant to the Agreement. As a part of this multifaceted study, peers were trained as research assistants in interviewing consumers annually to gather information about their functioning and perceptions about their lives. The interview protocol, which was designed with the input of peers, is included in Appendix-C. Table-10 summarizes some of the data from these interviews. The table shows the percentages and raw numbers of individuals who report positive outcomes relating to community living during an initial (Baseline) interview and a follow-up interview one year later. The final two columns indicate for each factor the percentage and number of individuals whose reports indicate positive change over the year and those indicating no change. The greatest gains were found with regard to consumers reporting that they have treatment goals that *they* direct (27.5%), that they feel control over their life (18%), that they are abstaining from tobacco use (15.9%), and that they have positive feelings of self-worth (15%). These outcomes reflect well on the system's overall efforts to promote recovery.

It is notable that the CRISP population includes individuals with significant challenges. In fact, referrals were made to the CRISP program in part based upon a finding that ACT services would not be sufficient to support them in the community. The University of Pennsylvania study found that inpatient use among the CRISP population was minimal, and that all individuals were able to remain in community settings. Also interesting was the finding that, based upon a widely used measure of psychiatric functioning,[20] individuals' symptoms actually increased over the year (on average, by 16%), but this evidently did not have an impact on their ability to live in integrated settings, nor did it affect the positive self-reports summarized in the table below. All in all, the ongoing CRISP study is further

[20] The Brief Psychiatric Rating Scale was used.

evidence from the State's extensive dataset that community services do work to the benefit of individuals with SPMI, including those with very significant challenges.

Table-10
CRISP Consumer Self-Report Data

DOMAIN	Baseline % +	12. mo. % +	% + change	% no change
Health Status *Baseline (n = 46); 12 mo. (n = 45)*	80.4% (37)	71.1% (32)	11.1% (5)	73.3% (33)
Control of Life *Baseline (n = 48); 12 mo. (n = 44)*	79.2% (38)	79.5% (35)	18.2% (8)	63.6% (28)
Satisfactory Housing *Baseline (n = 48); 12 mo. (n = 43)*	87.5% (42)	83.7% (36)	11.6% (5)	72.1% (31)
Feelings of self-worth *Baseline (n = 46); 12 mo. (n = 43)*	73.9% (34)	69.8% (30)	15% (6)	65% (26)
Abstinence from tobacco *Baseline (n = 49); 12 mo. (n = 44)*	42.9% (21)	38.6% (17)	15.9% (7)	63.6% (28)
Staff believe in consumer growth and recovery *Baseline (n = 48); 12 mo. (n = 44)*	91.7% (44)	77.3% (34)	9% (4)	68.2% (30)
Consumer directed treatment goals *Baseline (n = 46); 12 mo. (n = 43)*	73.9% (34)	81.4% (35)	27.5% (11)	55% (22)
Happy with friendships *Baseline (n = 49); 12 mo. (n = 44)*	83.7% (41)	79.5% (35)	13.6% (6)	68.2% (30)
Feeling a part of the community *Baseline (n = 49); 12 mo. (n = 44)*	81.6% (40)	81.8% (36)	13.6% (6)	68.2% (30)

QA/PI Activities Relating to Crisis Stabilization

As was referenced in Section IV, the parties negotiated a set of QA/PI measures to provide a fuller picture of the State's efforts to reduce hospital use by members of the target population than was required in provisions III.D.3-4 of the Agreement. These measures represent the basis for important QA/PI activities—some ongoing and some to be launched in the future—and, for this reason, they are discussed here. The new measures are presented in Table-11. In addition to these, the parties agreed

that the State would also focus some of its Quality Assurance activities on understanding and better addressing factors that may obscure its measurement of services, outcomes, and needs of people with SPMI who are served through State-funded programs, for instance, questionable diagnosing within the IMDs of individuals who may not have SPMI. Presented below are detailed data relating to the revised measures of compliance (Table-11), followed by a discussion of the State's progress relating to these diagnostic challenges.

Table-11
Revised Measures of Compliance
with Crisis Stabilization Provisions III.D.3-4[21]

Bed Days	
1a	Monthly Bed-Day Reports
1b	FY16 DPC Admissions from an IMD, by IMD and the Total LOS
1c	Mean, median, mode, and range of Days for 1b who have been discharged
1d	Clients whose lengths of stay have exceeded 14 days
1e	Direct admissions to DPC (i.e. not via an IMD)
1f	Mean, median, mode, and range of Days for 1e who have been discharged
1g	Removed[22]
1h	ALOS at DPC by LOS Type: 0-14, 15-49, 50-179, 180+ days
1i	Number of persons & length of time for each person on DPC ready to discharge list
Crisis Walk-In Centers	
2a	Number of individuals evaluated at RRC
2b	Diversion from hospitalization by RRC
2c	IMD admissions (from 1a) via Crisis Walk-In Centers
2d	IMD admissions (from 1a) not evaluated via Crisis Walk-In Centers
Engagement in Community Services Comprised by the Settlement Agreement	

[21] As agreed to by the parties on February 16, 2016. With minor differences, this table was included in the Monitor's Ninth Report (Table-1).
[22] With the agreement of the parties, item 1g has been removed because it was duplicative of item 1d.

3a	Hospital admissions of people who are actively served by DSAMH/PROMISE
3b	DSAMH community provider participation in discharge planning of 3a at IMDs & DPC
3c	Hospital admissions relating to people NOT being served by DSAMH/PROMISE
3d	3c who were referred for specialized services
3e	3c approved for specialized services
3f	3c found ineligible for specialized services
3g	3c approved, but refusing specialized services
3h	Removed[23]
3i	Removed
3j	Timely engagement of community provider/TCM in discharge planning of 3c individuals
3k	State's progress on addressing the 454 high-risk consumers identified in 2014[24]
Co-Occurring Substance use	
4a	IMD admissions with substance use as one of the discharge diagnosis
4b	4a receiving mental health services via DSAMH/PROMISE prior to admission
Homelessness	
5a	3a who are homeless
5b	5a who have been referred for housing (newly referred + already active)
5c	3c who are homeless and referred for DSAMH services
5d	5c who have been referred for housing
5e	3a who were discharged from hospital to shelters
5f	3c who were discharged from hospital to shelters
Hospital Readmissions	
6a	Persons discharged from DPC and each IMD in FY15
6b	30-, 90-, 180-, and 365-day Readmission Rates by LOS type

[23] Measures 3h and 3i related to participation in new PROMISE services. These measures have been removed because these services are still being developed. The State intends to incorporate monitoring of the use and impact of new PROMISE services in its Quality Assurance and Performance Improvement program once they are fully operational.

[24] The parties have agreed that Measure 3k will not be used in assessing the State's compliance because it has been subsumed by other actions the State is taking to engage high-risk individuals in services. Discussion of this measure is included for purposes of providing an update on the State's progress in addressing this issue, which was cited in previous Monitor reports.

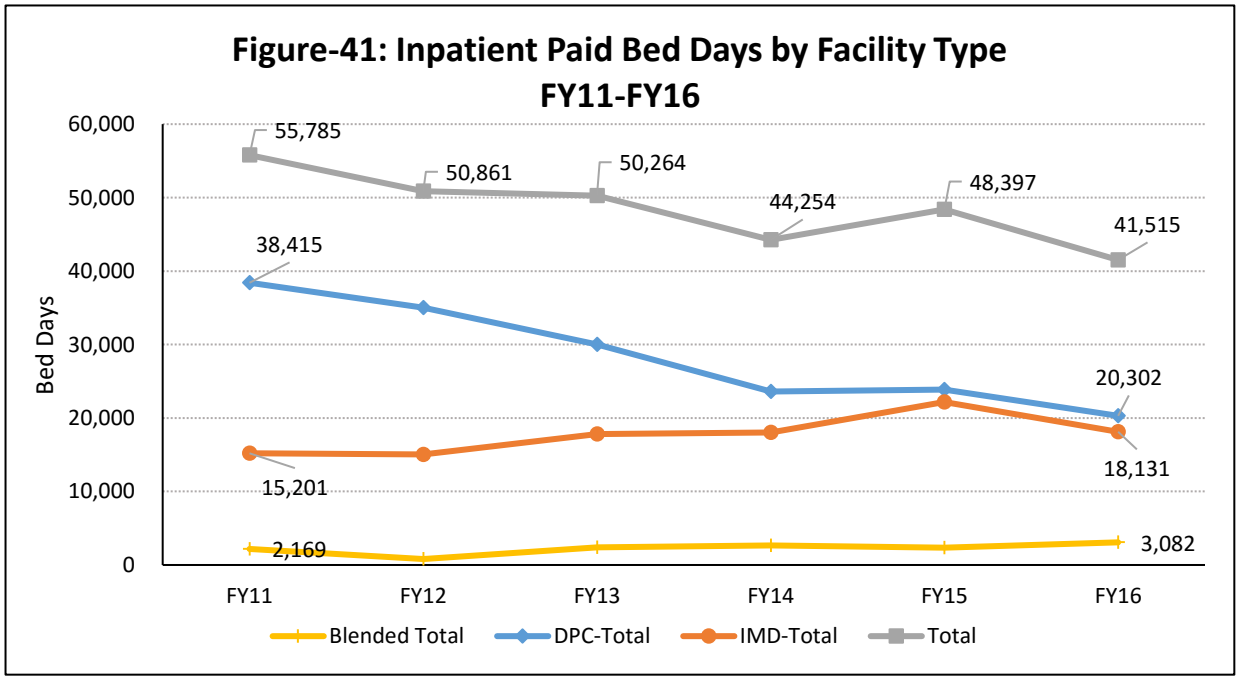
6c	1, 2, 3, or 3+ readmits to an IMD/DPC during a Fiscal Year
Reliance Upon Court-Ordered Treatment	
7a	Involuntary Outpatient Commitments FY11 to FY15
7b	Involuntary Inpatient Commitments FY11 to FY15
DPC Average Daily Census Report	
8	Data on Civil Units only

As of the Monitor's Ninth Report, the new approach to measuring the bed-day reduction provisions of Crisis Stabilization Services had been in effect for only 2 ½ months. Although some of the measures included in the above table had been a part of the State's ongoing data collection, others were new. Based upon the State's substantial efforts to move forward on the quantitative and qualitative components of the revised approach, the Ninth Report rated the State as "Moving Towards Substantial Compliance" with respect to Crisis Stabilization. As is documented below, the State is now in Substantial Compliance with the Agreement's Crisis Stabilization provisions, as well as with provisions relating to QA/PI. The tables and figures that follow detail the State's status with respect to each measure included in Table-11.

1. Bed Day Measures

The first set of measures relates to individuals with SPMI who have been hospitalized in DPC or one of the IMDs with State funding, their lengths of stay, and timeliness of discharge. The State has been monitoring total bed days used by the target population since the Agreement went into effect in Fiscal Year 2011. Figure-41 presents the bed days used for each of the five years of implementation for DPC and, combined, for the three IMDs. It also includes a small number of "Blended" hospitalizations, relating to individuals who were admitted to an IMD and who were subsequently transferred to DPC for continuing inpatient care because they were not stabilized within the relatively short treatment periods to which IMD care is directed. The bed-day figures include individuals categorized as receiving Long Term Care (in excess of 180 days), Intermediate-II Care (50-179 days), Intermediate-I Care (15-49 days), and Acute Care (14 days or fewer). DPC serves individuals falling into each of these categories. Bed use in the IMDs overwhelmingly falls within the Acute Care category; very few hospitalizations extend into either of the Intermediate Care categories, and none extend into Long Term Care. As is

depicted in Figure-41, comparing FY 2011 with FY 2016, DPC has reduced the number of bed days[25] used by the target population by 47.2%, from 38,415 to 20,302. These reductions have mostly occurred with regard to Long Term Care (a 55.3% reduction from FY 2011), but were also realized in Intermediate Care-I and -II and Acute Care (8.7%, 4.4%, and 4.5% reductions, respectively). Care within the IMDs, which is mostly for 14 days or fewer, increased significantly between 2011 and 2015. Possibly reflecting some of the early effects of PROMISE and other improvements that the State has made in coordinating services between DSAMH, DMMA, the MCOs, and the IMDs, the number of bed days used by the target population in the IMDs dropped during the past year, from 22,179 in FY 2015 to 18,131 in FY 2016. This is the first time this figure has declined in five years of the Agreement's implementation.



Nevertheless, as of the end of FY 2016, IMD bed days were 19.3% higher than they were in FY 2011. Moving forward, it will be important for the State to closely monitor whether, in fact, FY 2016 showed the beginning of a new downward trajectory and, with the prospect of a new IMD opening in Sussex

[25] Only non-forensic bed-days are counted.

County, whether it can continue to reduce acute care hospitalizations for people with SPMI. Figure-41 shows the so-called Blended hospitalizations, which reflect the total of initial hospital days in an IMD followed by hospital days in DPC, as being relatively flat over the course of implementation. All told, the bed days from DPC, the IMDs, and Blended hospitalizations that entail both DPC and an IMD have dropped from 55,785 in Fiscal Year 2011 to 41,515 in Fiscal Year 2016, a 25.6% reduction.

Figure-42 combines hospitalizations among all facilities and presents aggregate data based upon length of stay for each year of implementation. It shows that Long Term hospitalizations dropped significantly between Fiscal Year 2011 and Fiscal Year 2014, a period during which the State was developing its array of intensive community services (such as Assertive Community Treatment) and Supported Housing. Since 2014, Long Term Care has pretty much leveled off. Both categories of Intermediate Care have remained relatively stable during the implementation period. Acute Care in the IMDs and DPC has increased and, consistent with the discussion above, appears to begin to drop in Fiscal Year 2016.

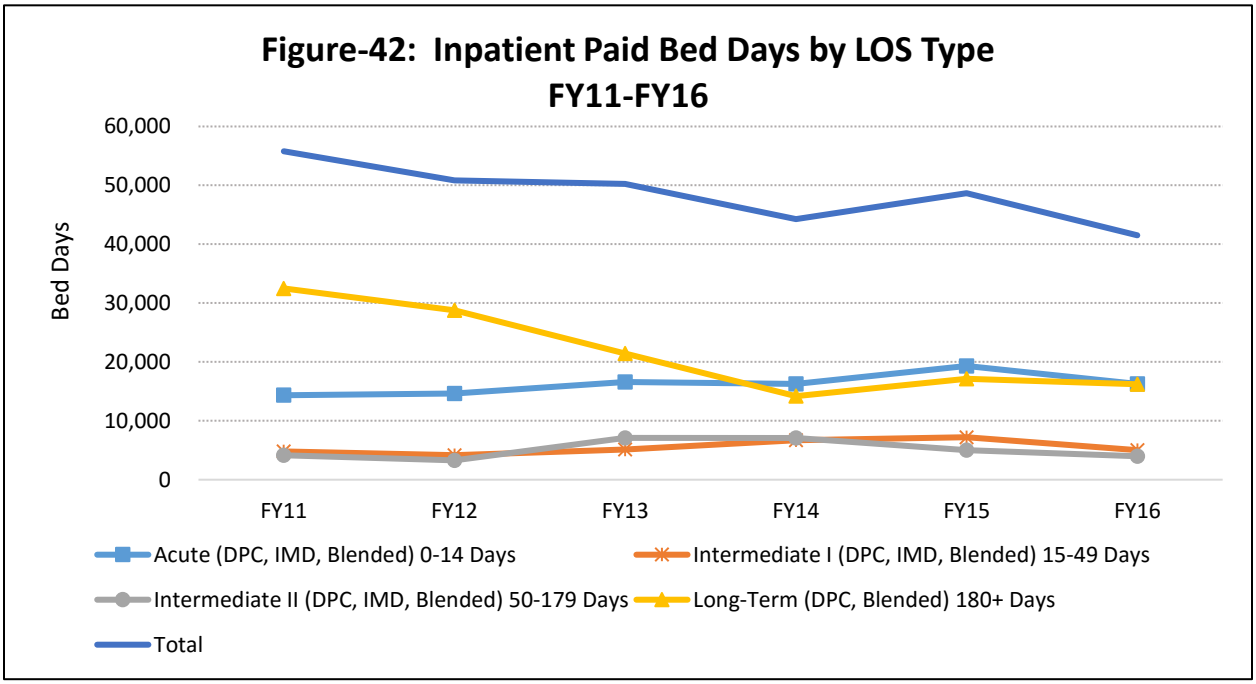


Table-12 provides additional information about the episodes of hospitalization for people transferred to DPC from an IMD; it responds to Measure 1c in Table-11. Table-12 shows DPC discharges during Fiscal Year 2016, including from blended hospitalizations where IMD transfers may have occurred during that year or earlier. Twenty-two such discharges following a blended hospitalization took place, with combined IMD and DPC hospital episodes ranging from 9 days to a high of 966 days. The Mean and Median data for these hospitalizations show that these extremes are, in fact, outliers. On average, blended hospitalizations lasted 134.9 days and the median number of days—that is, the number of days that 11 of these 22 individuals were hospitalized—is 59.0. By either measure, these are long hospitalizations, an outcome that is consistent with the premise that individuals who are transferred from IMDs to DPC have complex clinical issues that are not amenable to being resolved within the Acute Care periods to which IMD services are oriented.

Table-12: DPC Lengths of Stay by Admission Type
FY16

Admission Type	n of Discharges	Mean Bed Days	Median Bed Days	Range of Bed Days
Direct DPC	199	132.1	25.0	2 - 6,470
IMD Transfers Total	22	134.9	59.0	9 - 966
From Dover	10	236.3	66.0	9 - 966
From MeadowWood	3	160.3	57.0	37 - 387
From Rockford	9	114.3	61.0	23 - 413
Total	221	132.4	27.0	2 - 6,470

Table-13 concerns Measure 1d in Table-11, which relates to Blended hospital stays in which an individual is transferred from an IMD for longer term inpatient treatment a DPC. It shows that during Fiscal Year 2016, sixteen such individuals were transferred to DPC. The State calculates their lengths of stay as a single episode and, not surprisingly, virtually all of them (93.8%) remained hospitalized beyond the Acute Care period of fourteen days.

Tables-12 and -13 include the data required in Measure 1b in Table-11, that is, the total number of individuals who were admitted to DPC from an IMD by IMD during Fiscal Year 2016 (16 individuals) and lengths of stay (which can only be determined once they are discharged—i.e., Table-12).

Table-13: Lengths of Stay beyond 15 Days for Direct DPC Admissions vs. IMD transfers FY16			
Admission Type	**n of Admissions**	**n of Total LOS >=15 Days**	**% of Total LOS >=15 Days**
Direct DPC	193	128	66.3%
IMD Transfers Total	16	15	93.8%
From Dover	6	5	83.3%
From MeadowWood	3	3	100.0%
From Rockford	7	7	100.0%
Total	209	143	68.4%

Table-14 presents data on how Blended hospital stays have trended during the course of the Agreement. Because the numbers are so small, calculations of changes from Fiscal Year 2011 to Fiscal Year 2016 are not very meaningful for individual length-of-stay categories, but it is notable that there has been a 27.5% reduction in the overall number of Blended hospitalizations during this period.

Table-14: Number of Blended Hospitalization Episodes by Length-of-Stay Category FY11- FY16							
Stay Type	**FY11**	**FY12**	**FY13**	**FY14**	**FY15**	**FY16**	
Blended-Acute (0-14 Days)	3	3	0	2	1	1	**% Change (FY11-FY16)**
Blended-Intermediate I (15-49 Days)	22	7	13	26	7	8	
Blended-Intermediate II (50-179 Days)	13	5	16	13	10	12	
Blended-Long Term (180+ Days)	2	2	4	4	9	8	
Blended-Total	40	17	33	45	27	29	27.5% Red.

With respect to Measure 1e in Table-11, and as is presented above in Table-13, DPC reported a total of 193 direct admissions during Fiscal Year 2016. These included individuals with complex needs and long histories of treatment at DPC who need additional hospital treatment, as well as individuals in need

of Acute Care –particularly those who lack Medicaid or other insurance that would cover hospitalization at an IMD.

Table-15 presents data that responds to Measures 1f and 1h in Table-11, that is, statistics relating to individuals who were directly admitted to DPC. Although the State maintains such data for other periods as well, this table includes information for Fiscal Year 2016 only. 30.2% of individuals discharged had durations of hospitalization that fell within the category of Acute Care (i.e., 14 days or fewer). 42.7% had Intermediate-I lengths of stay (15-49 days), 14.1% had Intermediate-II lengths of stay (defined as 50-179 days, but with a range of 51-170 days for these 28 individuals), and the remainder had hospital stays in excess of 180 days.

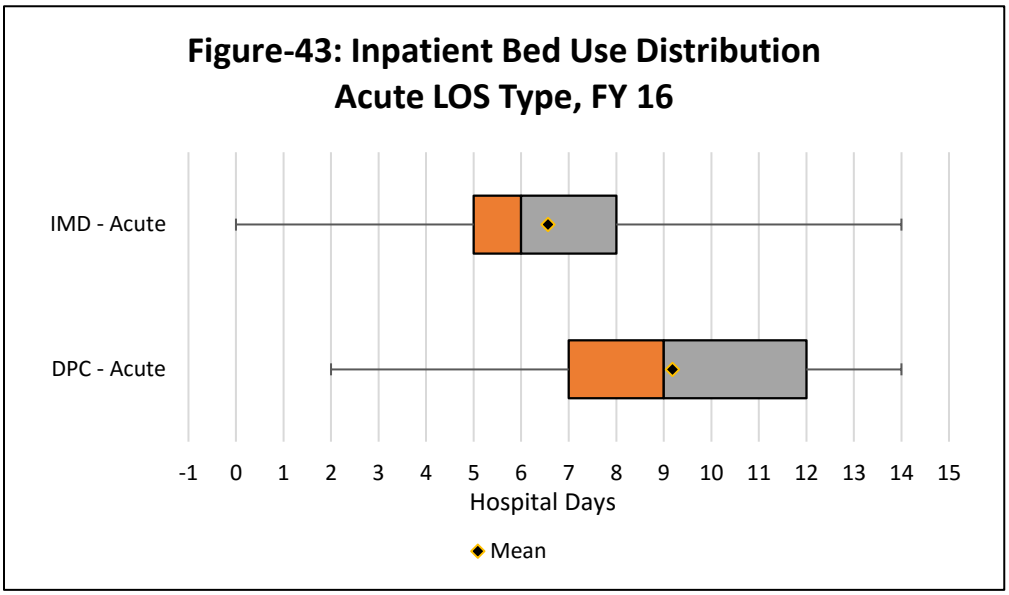
Table-15: Discharges from DPC by Length of Stay Category (Direct Admissions Only) Fiscal Year 2016

Admission Type	Number of Discharges	Mean Bed Days	Median Bed Days	Range of Bed Days
Acute	60	9.2	9.0	2 - 14
Intermediate I	85	27.5	26.0	15 - 49
Intermediate II	28	86.3	70.5	51 - 170
Long Term	26	807.2	299.5	185 - 6,470
Total	199	132.1	25.0	2 - 6,470

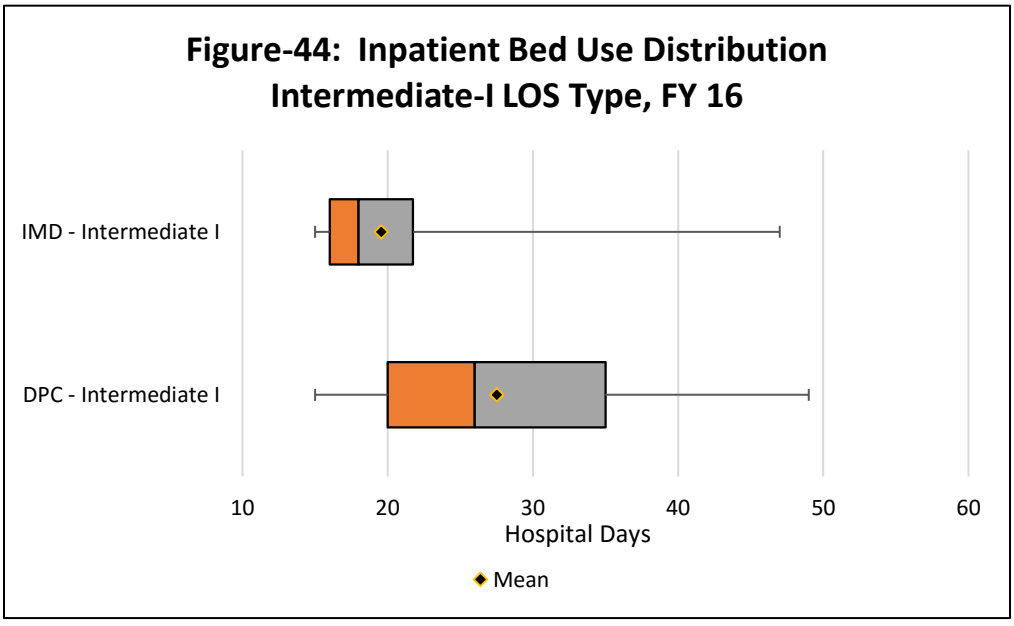
Figures-43, -44, and -45 clarify the meaning of these data. They present the distributions for lengths of hospitalizations in DPC and the IMDs within the categories of Acute Care, Intermediate-I, and Intermediate-II, respectively.[26] In each figure, the horizontal lines (sometimes called the "whiskers") show the range of bed days used during Fiscal Year 2016. The box represents the second and third quartiles within this range, and the vertical line indicates the median (the length of stay reflecting 50% of the individuals in the group). The mean, indicated by a diamond, is the average length of stay for the group. As is shown in Figure-43, the mean and median for Acute Care discharges from DPC are about 9 days, or slightly longer than tends to be the case in the IMDs. It is likely that this difference is

[26] Long Term Care discharges were not included because there is no defined upper limit to this category.

attributable to the fact that the admission and discharge processes at DPC, which entail multidisciplinary assessments and formal team meetings, are more involved than those utilized within the IMDs.

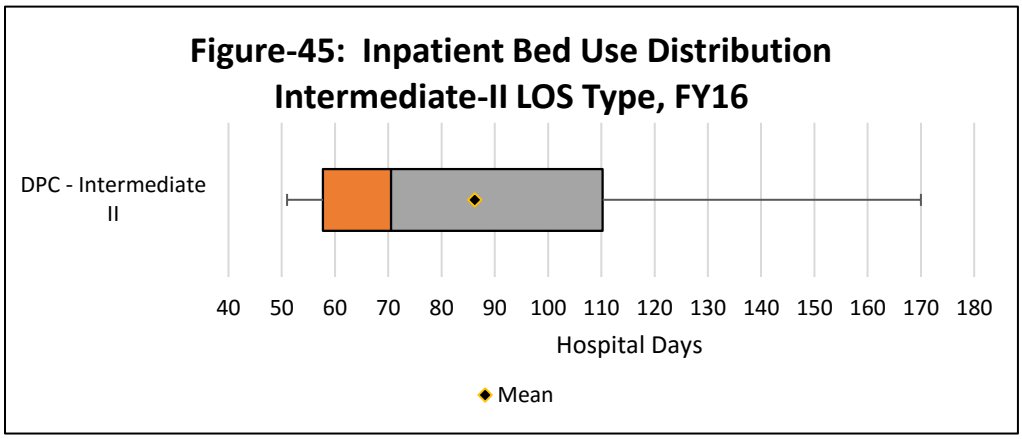


Individuals with Intermediate-I lengths of stay represent only a small fraction of hospital discharges from the IMDs. The number of discharges from IMDs in Fiscal Year 2016—2,554—is almost thirteen times larger than those from DPC (199), and virtually all of the hospitalizations in IMDs (95%) were for



Acute Care. Only about 5% of IMD discharges followed Intermediate-I lengths of stay. As is indicated in Figure-44, they tend to last only a few days longer than Acute Care. Figure-44 shows that within DPC, Intermediate-I hospitalizations tend to be around 26 or 27 days, and that three-fourths of the hospitalizations in this category (the right-hand side of the box represents three quartiles) are between 15 and 35 days (49 days is the upper limit for this category).

Intermediate-II lengths of stay (defined as from 50 to 179 days) are extremely rare in the IMDs. Only 2 such instances occurred in Fiscal Year 2016.[27] Figure-45 shows that three-quarters of the individuals whose inpatient stays fell into the Intermediate-II category were discharged within 110 days.



Tables-16 and -17 present length-of-stay data for the IMDs similar to what was discussed above with respect to DPC, and which is included in Figures-43 and -44. Notable in Table-17 is that the number of hospitalizations extending beyond Acute Care is small, and that the Mean and Median of these hospitalizations (19.6 and 18.0, respectively) are only a few days beyond what would be considered Acute Care. Intermediate-II lengths of stay (beyond 49 days) is a rarity, reflecting only 0.1% of discharges.

[27] Because the number of Intermediate-II hospitalizations in IMDs is so small, their inclusion in the related distribution chart would not be meaningful.

Table-16: IMD Length-of-Stay Statistics by Facility FY16				
Admission Location	**n of Discharges**	**Mean Bed Days**	**Median Bed Days**	**Range of Bed Days**
IMD	2,554	7.2	6.0	0 - 69
Dover	626	8.3	7.0	0 - 69
MeadowWood	911	6.1	5.0	1 - 37
Rockford	723	7.8	7.0	0 - 54
IMD not identified	294	7.3	7.0	2-36

Table-17: IMD Statistics by LOS Type FY16					
Admission Type	**n of Discharges**	**Percent of Discharges**	**Mean Bed Days**	**Median Bed Days**	**Range of Bed Days**
Acute	2,426	95.0%	6.6	6.0	0 - 14
Intermediate I	126	4.9%	19.6	18.0	15 - 47
Intermediate II	2	0.1%	61.5	61.5	54 - 69
Total	2,554	100.0%	7.2	6.0	0 - 69

2. Crisis Walk-In Centers

The second set of measures relating to Crisis Stabilization concern the impact of the Crisis Walk-In Centers in evaluating individuals who are at immediate risk of hospitalization, providing crisis intervention and, as appropriate, diverting them from inpatient care. As is discussed in the section of this report dealing with provisions of the Agreement about Crisis Walk-In Centers, the State has an effective program operating in southern Delaware through the "living room model" of services, and it has just recently replaced its hospital-based walk-in center in northern Delaware with a parallel program. Because of the newness of the northern Delaware program, the State does not yet have data on its operations, but it does maintain and review comprehensive information about the Recovery Resource

Center (RRC), which operates in Ellendale. Table-18 presents the State's data relating to Measures 2a, 2b, 2c, and 2d in Table-11 for Fiscal Years 2014 and 2015 (it has not yet analyzed data for Fiscal Year 2016). It shows the increasing utilization of the RRC between these years, from 1,760 evaluations in Fiscal Year 2014 to 2,183 in Fiscal Year 2015. For both years, the rate of diversion from hospitalization has exceeded 70%.

Dover Behavioral Health is the IMD serving southern Delaware. In past years, this and the other two IMDs have had substantial numbers of direct admissions for State-funded care of individuals with SPMI without prior screening and evaluation by a Crisis Walk-In Center. In some instances, such admissions have been approved by DSAMH, for instance when an individual is at an immediate and serious risk of self-harm that clearly cannot be addressed outside of a hospital. In other instances, individuals present themselves at IMDs for admission or various emergency entities (such as police or emergency departments of general hospitals) have initiated direct transfers. During the past year or so, the State has taken steps to ensure that, unless circumstances dictate otherwise, individuals are afforded RRC assessments before hospitalization occurs—particularly when such assessments are part of the civil commitment process.

As was discussed earlier, Delaware's mental health law provides for a 24-hour hold to determine whether an individual who is in crisis is in need of involuntary hospitalization and whether less restrictive measures are appropriate. In the past, such 24-hour assessments have occurred within IMDs where, for a variety of reasons, they virtually always culminated in hospitalization. By assigning this function to the RRC, the State has appropriately sought to distinguish a 24-hour assessment period from hospitalization itself, which increases opportunities for diversion. For this reason, Measures 2c and 2d in Table-11 examine IMD admission with and without prior evaluation at the RRC. As is reflected in Table-18, over 75% of IMD admissions in southern Delaware relating to members of the target population were first evaluated and approved by the RRC. Of those hospital admissions not pre-screened in this way, some direct admissions by IMDs were at DSAMH's direction due to a risk of imminent harm. These are important measures of performance that the State plans to extend to the new RRC serving the northern part of the Delaware in that they provide opportunities to ensure that individuals are afforded the least restrictive care appropriate (in keeping with State and federal laws) and to drive further improvements in the system's programs for early intervention and crisis prevention.

Table-18: Southern Delaware Referral and Diversion Breakdown		
	FY14	**FY15**
Number of Individuals Evaluated at RRC Crisis Walk-In Center	1760	2183
Number Diverted from Hospitalizations	1386	1627
% Diverted	78.75%	74.53%
Number of Dover Behavioral Health IMD Admissions	476	730
Number of IMD Admissions Evaluated by RRC	374	556
% of IMD Admissions Evaluated by RRC	78.57%	76.16%
Number of IMD Admissions Not Evaluated by RRC	102	174
% of IMD Admissions Not Evaluated by RRC	21.43%	23.84%

3. Engagement in Community Services

The third set of new measures relating to Crisis Stabilization reflects the State's efforts to reduce the risk of crises leading to hospitalization by engaging members of the target population in the network of community services comprised by the Agreement. Table-19 presents data on hospitalizations among the target population to an IMD or DPC during Fiscal Years 2015 and 2016 based upon individuals' engagement in specialized community mental health services (through either PROMISE or DSAMH) at the time of hospital admission. The top half of the table presents data on all such hospital admissions during these periods; the lower half of the table reflects unduplicated data—that is, it takes into account that some individuals had more than one admission during a year. From either perspective, the findings of this analysis are striking. Individuals who are receiving specialized services have dramatically lower rates of admission than do those who are not receiving services such as ACT, Intensive Care Management, Supported Housing, and other services required by the Agreement. For instance, the unduplicated figures for Fiscal Year 2016 show that only 9.9% of hospitalizations involved individuals receiving specialized community services, 89.5% were not receiving these services, and a small number

Table-19: Hospitalizations of Individuals Based on Engagement with Specialized Mental Health Services				
	FY15 (Jan to Jun)		FY16 (Jul to May)	
	n	%	n	%
Hospital Admissions	1775		2696	
Hospital Admissions Relating to DSAMH/PROMISE Clients	247	13.9%	301	11.2%
Hospital Admissions Not Relating to DSAMH/PROMISE Clients	1528	86.1%	2395	88.8%
Clients Admitted to Hospitals (Unduplicated)	1339		1913	
PROMISE Clients Admitted to Hospitals	159	11.9%	189	9.9%
Non-PROMISE Clients Admitted to Hospitals	1173	87.6%	1712	89.5%
Individuals Admitted to Hospitals both as non-PROMISE and PROMISE Clients	7	0.5%	12	0.6%

(0.6%) were enrolled in specialized services during the course of the year.[28] Enrollment in PROMISE (or DSAMH) services entails a careful review by DSAMH of individuals' clinical diagnoses and service needs. In other words, provider records of these individuals have been reviewed by DSAMH's Eligibility and Enrollment Unit (EEU) to determine that, in fact, they have SPMI and that they have functional impairments that necessitate specialized services. That individuals with such documented levels of impairment represent such small numbers of hospital admissions—only 189 in Fiscal Year 2016—reflects very positively on the overall effectiveness of Delaware's programs to address the needs of inherently high-risk individuals, in keeping with the requirements and intent of the Agreement.

Individuals not enrolled in PROMISE have been given diagnoses of SPMI (generally by IMDs), but either they have not been referred for PROMISE or the EEU has determined that they do not have SPMI or a need for specialized services. Monitor reports from past years noted that the State's referral processes for specialized services was poorly coordinated and, in many respects, arbitrary. During the past two years, the State has made important improvements by creating clear triggers for referral, streamlining procedures for making referrals, and monitoring related quality indicators. Table-20

[28] Most likely, their hospitalizations triggered referrals for PROMISE services.

presents the cumulative number of referrals for specialized mental health services since PROMISE was launched in January, 2015, totaling 3,059 as of the end of the 2016 fiscal year. As the State's enrollment processes became fully operational, the number of referred individuals awaiting PROMISE determinations dropped from 36.6% in December of 2015 to only 1% in June of 2016. Cases closed, including reviews determining that individuals are ineligible, have increased to almost 30%.

Table-20: Breakdown of New PROMISE Referrals

	Cumulative Referrals					
	As of 12/31/15		As of 4/30/16		As of 6/30/16	
	n	%	n	%	n	%
Clients Referred for Specialized Mental Health Services	2137		2877		3059	
Clients Approved for Specialized Services	873	40.9%	1808	62.8%	2117	69.2%
Clients Closed (Ineligible, Refused, Moved, etc.)	481	22.5%	713	24.8%	912	29.8%
Clients Waiting Determination	783	36.6%	356	12.4%	30	1.0%

Taken as a whole, Tables-19 and -20 document that the State is making significant progress in engaging individuals with SPMI with the intensive services they need to live in the community. These services for people determined to have significant disabilities appear to be effective in preventing their hospitalization. And, perhaps reflecting diagnostic practices in IMDs discussed earlier in this report, about 9 out of 10 hospitalizations occur with respect to people *not* receiving specialized services. While these individuals have been given SPMI diagnoses, either their diagnoses and service needs were not validated in EEU reviews, services were not implemented because of other factors (e.g., client refusal), or they were not referred. Because non-PROMISE clients account for about 90% of the State-funded hospital admissions (representing very significant public expenditures), and given the evident effectiveness of PROMISE services in preventing hospitalizations of individuals with SPMI, the State should redouble its efforts to understand why these admissions are occurring in such high numbers.

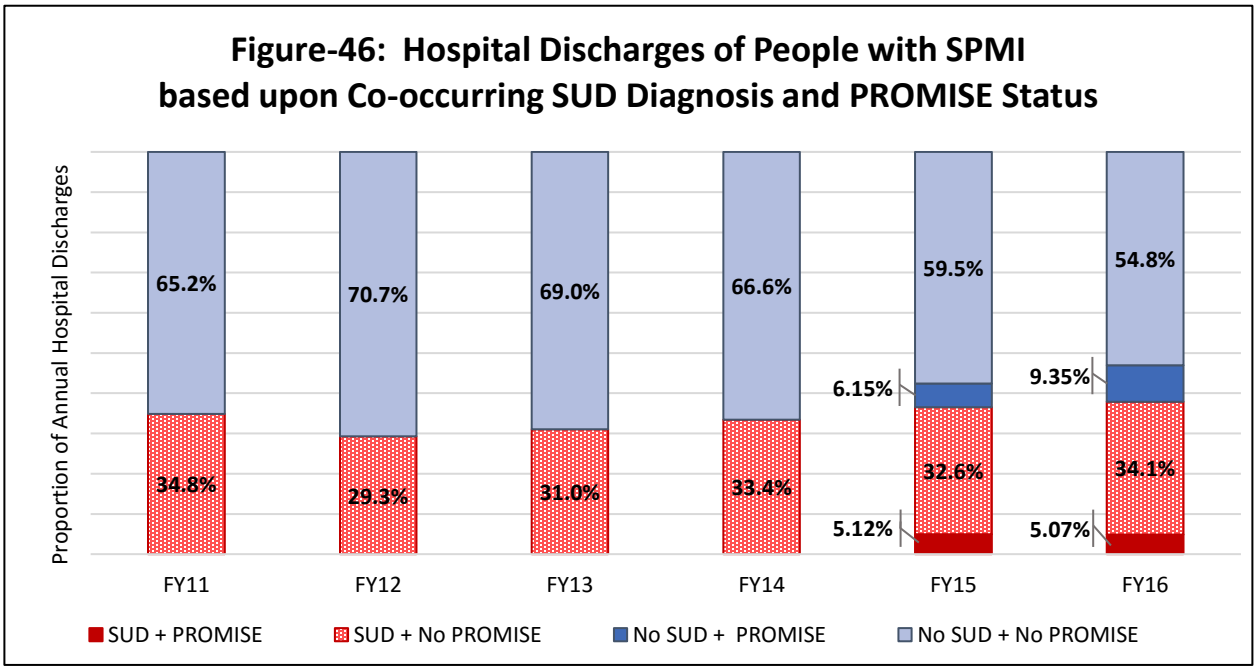
Measure 3j in Table-11 concerns the timeliness of provider contact with members of the target population who are hospitalized. This issue was discussed above in the section "Community Provider Involvement," and related statistics were presented in Figures-12 and 13.

Measure 3k in Table-11 relates to the State's progress in referring for specialized mental health services 454 high-risk individuals, who were identified in 2014. As has been discussed in earlier Monitor reports, these individuals, who had multiple psychiatric hospitalizations, appeared to have clear needs for specialized mental health services but were not referred via the IMDs, MCOs, or another entity under the arrangements that were in effect at the time of their hospitalizations. In response (and also as discussed in past Monitor reports), the State launched an aggressive program of outreach and engagement, although due to the time lag since the hospitalizations occurred, it had only mixed results. As was discussed above, the State has since significantly improved its system for referring individuals with SPMI for specialized services and, for instance, if they come to be hospitalized, a referral for PROMISE is now assured. Furthermore, it has notified the MCOs of beneficiaries who were members of this high-risk group so that engagement efforts can occur even absent hospital admission. In light of these factors, Measure 3k in Table-11 is essentially subsumed by the other monitoring efforts discussed in this section.

4. Co-Occurring Substance Use Disorders

As was referenced earlier, many informants have indicated that individuals who primarily have substance use disorders (SUD) were being admitted to IMDs and diagnosed with SPMI. While these individuals may have a need for intensive services, psychiatric hospitalization may not be the most appropriate course of treatment. Furthermore, for purposes of monitoring the Agreement's provisions with respect to psychiatric hospital bed use by the target population, such admissions may artificially inflate inpatient numbers attributed to people with SPMI. With the intent of better positioning the State to address this issue, measurements were included to reflect the determination (upon hospital discharge) that individuals diagnosed with SPMI also have substance use issues. Figure-46 presents data from Fiscal Year 2011 through Fiscal Year 2016 reflecting the breakdown of hospital discharges of the target population with—and without—SUD diagnoses in addition to SPMI diagnoses. For Fiscal Years 2015 and 2016, Figure-46 also includes information on whether or not individuals were receiving specialized

mental health services (via PROMISE).[29] It shows that SUD diagnoses represent increasing proportions of discharges between individuals with and without PROMISE, accounting for 37.7% of discharges in 2015 (32.6% + 5.1%) and 39.2% (34.1% + 5.1%) in 2016. Furthermore, and in keeping with data discussed earlier, whether or not individuals have been diagnosed with SUD, individuals receiving PROMISE services account for only a small proportion of hospitalizations. In fact, for each of these fiscal years, only 5.1% of the hospital discharges related to individuals with SPMI (as vetted via the PROMISE eligibility process) and who also had SUD.



5. Homelessness

Homelessness is an important risk factor for hospitalization, and is specifically referenced in the Agreement in defining priority populations for community services.[30] The Target Priority Population List identifies 905 individuals who have histories of homelessness. While they represent 7.1% of the total number of individuals on the list, because these numbers may well be inflated by individuals who do not have SPMI (e.g., due to the diagnostic practices referenced earlier), they likely represent a larger proportion of the population to which the Agreement is directed. For instance, the Monitor's regular

[29] Enrollment information in DSAMH services predating PROMISE was not available.
[30] Section II.B.2.f

meetings with members of the target population find that self-reports of prior homelessness are very commonplace. As was discussed earlier with respect to the Agreement's Supported Housing provisions, the State has consistently met or surpassed its requirements for funding integrated mainstream housing that prioritizes homeless individuals. Furthermore, DPC has been diligent in ensuring that homeless individuals are linked with housing, and it is now extremely rare and indicative of special circumstances when homeless individuals are discharged to shelters.

In part because of the past diffuse oversight of referrals of Medicaid-covered individuals for specialized mental health services, homelessness was not being appropriately addressed for many individuals diagnosed with SPMI who were not served through DSAMH. Past reports of the Monitor described numerous instances in which such individuals were repeatedly admitted to IMDs, identified as homeless, and discharged back into homelessness. The State has since moved to aggressively remedy this situation and, with oversight by DSAMH and the MCOs, homeless individuals with SPMI are now regularly

Table-21: IMD Housing Assessment Homelessness Breakdown

	FY15 (Mar, Apr, Jun)		FY16 (Jul to Dec, Feb to Jun)	
	n	%	n	%
Hospital Admissions for State Funded Clients	947		2,524	
Homeless	47	4.96%	160	6.34%
Receiving DSAMH Services	9	19.15%	20	12.50%
Referred for EEU/TCM	11	23.40%	57	35.63%
Referred for TCM Only	19	40.43%	68	42.50%
Discharged to shelters	8	17.02%	14	8.75%
Dover	1	12.50%	13	92.86%
MeadowWood	1	12.50%	1	7.14%
Rockford	6	75.00%	0	0.00%

identified by the IMDs and referred for services, either via PROMISE or Targeted Care Managers. Because of the significant linkage between homelessness and the risk of hospitalization, a set of

indicators relating to the identification of homeless individuals and their referral for housing and other services was included in the revised format for measuring progress in reducing hospital bed use. Table-21 presents data relating to Measures 5a through 5f,[31] as delineated in Table-11. With regard to the individuals discharged from IMDs to shelters, all were offered alternative services, but declined those services.

6. Hospital Readmissions

In defining the priority service population, Section II.B of the Agreement identifies people with SPMI and histories of psychiatric hospitalization as at high risk of unnecessary institutionalization. Measure 6a in Table-11 is the number of individuals within the target population who were discharged from DPC or an IMD during Fiscal Year 2015, Measure 6b concerns their rates of re-hospitalization, and Measure 6c identifies the number of single and multiple readmissions during the year.

Tables-22, -23 and -24 present the State's analyses of discharges and readmission rates (i.e., Measures 6a and 6b) for the Fiscal Years 2011, 2014, and 2015, respectively.[32] The readmission rates are differentiated by the categories of lengths of hospitalization (i.e., Acute Care, Intermediate, etc.), as well as by the time periods since an individual's date of discharge—1-30 days, 31-90 days, 91-180 days, and 181-365 days. The readmission rates are calculated based upon an individual's re-hospitalization in any facility, not necessarily the same facility in which earlier hospital care had been provided.[33]

From year to year, there has been considerable variation in readmission patterns. In each year, readmission rates of people who were hospitalized for 14 days or fewer were highest during the first thirty days following discharge. Also notable, is that in every year the readmission rates of individuals who receive Long Term Care are low. In fact, in 2014, there were no readmissions of individuals who

[31] As is indicated, data for some months is missing because of incomplete submissions by the IMDs.
[32] Data for Fiscal Year 2016 was incomplete as of the time of this report.
[33] Delaware's data includes both its state-operated facility (DPC) and private psychiatric hospitals (IMDs). The most widely used national norms are compiled by the Substance use and Mental Health Services Administration of the Department of Health and Human Services, but they relate to state hospitals only. The 2015 SAMHSA national adult readmission rates for 30 days following discharge from a state hospital were 8.4%, and for 180 days were 18.9%. Reporting on DPC only, Delaware's rates as reported to SAMHSA were lower than the national norms, at 7.7% and 10.7%, respectively. But unlike the data presented in this report, which include hospitalizations and readmissions (with state funding) to any facility, SAMHSA's data reflects discharges from, and readmissions to, state hospitals only. The Monitor is not aware of any national norms that are comparable to the data presented here.

had been hospitalized for 181 days or longer. Among people discharged in Fiscal Year 2015, two individuals were readmitted within 30 days of discharge following Long Term Care at DPC,[34] and an additional readmission occurred between 31 and 90 days following discharge from DPC. No individuals who had received Long Term Care at DPC were readmitted that year following 91 days or beyond in the

Table-22: Inpatient Readmissions FY11

		1-30 Days		31-90 Days		91-180 Days		181-365 Days	
	Number of Discharges (FY11)	n	%	n	%	n	%	n	%
Acute	**2334**	308	13.20%	222	9.51%	175	7.50%	200	8.57%
Intermediate I	**187**	31	16.58%	14	7.49%	17	9.09%	9	4.81%
Intermediate II	**51**	4	7.84%	6	11.76%	2	3.92%	7	13.73%
Long Term	**37**	0	0.00%	0	0.00%	2	5.41%	1	2.70%
Total	**2609**	343	13.15%	242	9.28%	196	7.51%	217	8.32%

Table-23: Inpatient Readmissions FY14

		1-30 Days		31-90 Days		91-180 Days		181-365 Days	
	Number of Discharges (FY14)	n	%	n	%	n	%	n	%
Acute	**2042**	349	17.09%	231	11.31%	204	9.99%	236	11.56%
Intermediate I	**238**	44	18.49%	25	10.50%	20	8.40%	31	13.03%
Intermediate II	**90**	8	8.89%	6	6.67%	5	5.56%	8	8.89%
Long Term	**27**	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	**2397**	401	16.73%	262	10.93%	229	9.55%	275	11.47%

[34] As was indicated earlier, the IMDs do not provide Long Term Care so, although these tables do not identify the hospital, individuals readmitted following Long Term Care would have received that care at DPC.

Table-24: Inpatient Readmission FY15									
		1-30 Days		31-90 Days		91-180 Days		181-365 Days	
	Number of Discharges (FY15)	n	%	n	%	n	%	n	%
Acute	**2695**	442	16.40%	312	11.58%	244	9.05%	203	7.53%
Intermediate I	**308**	33	10.71%	42	13.64%	34	11.04%	25	8.12%
Intermediate II	**56**	9	16.07%	3	5.36%	3	5.36%	6	10.71%
Long Term	**22**	2	9.09%	1	4.55%	0	0.00%	0	0.00%
Total	**3081**	486	15.77%	358	11.62%	281	9.12%	234	7.59%

community. As was referenced earlier, this is an important accomplishment because of the clinical and social challenges affecting individual who require extended hospitalizations. Figure-47 provides a graphic representation of the readmission inpatient patterns following each category of hospitalization where discharges occurred during Fiscal Year 2015.

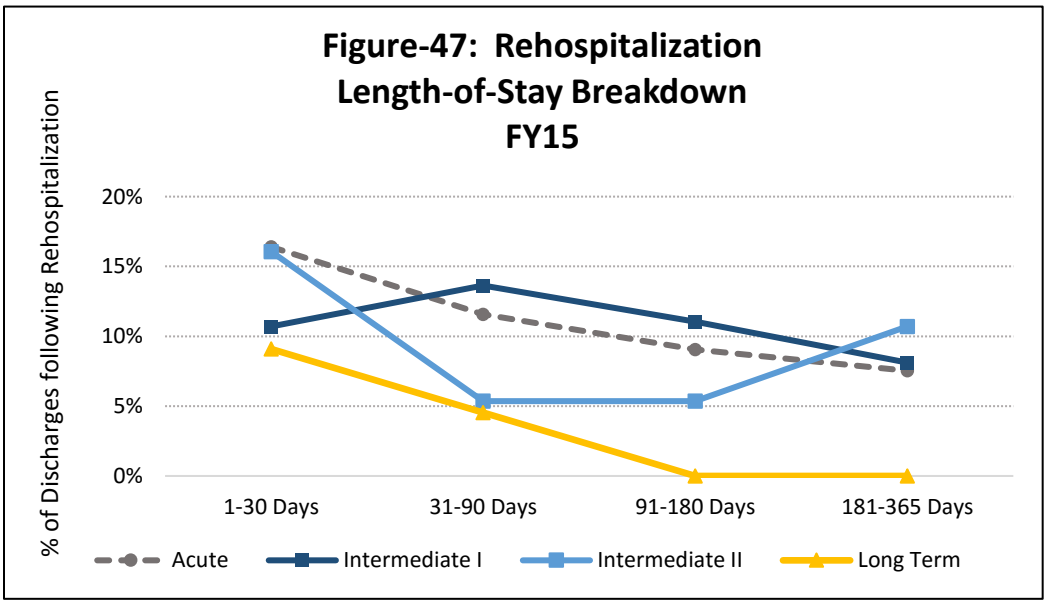


Table-25 responds to Measure 6c in Table-11, presenting the number of single and multiple readmissions in Fiscal Years 2011, 2014, and 2015. DSAMH has a Quality Assurance initiative relating to individuals who have multiple readmissions, including those represented in this table. This study

focuses on high-end users (at DPC and/or an IMD) with four or more hospitalizations, 30 days of inpatient care within a one-year period, or three hospital admissions within any 90-day period. The State's scan of various data sources revealed that 41 individuals met one or more of these criteria within the 2015 calendar year (it regularly updates its list). DSAMH established a High-End User Review Committee that is monitoring the status of and treatment afforded to these individuals, and is guiding actions to reduce their use of inpatient care. The Committee, which meets monthly, has been evaluating aggregate data and solicited providers' input as to strategies to mitigate the risk of readmissions. It will present its findings and recommendations to the DSAMH Steering Committee in September, 2016.

Table-25: Readmission Counts (All Hospitals)

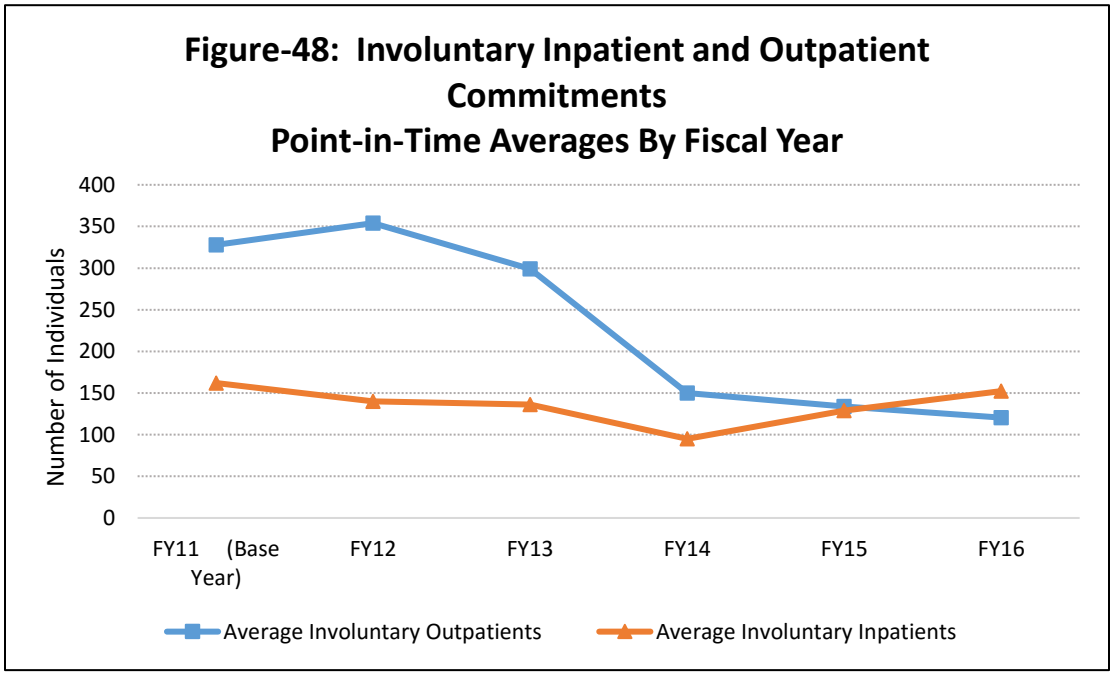
Number of Readmissions	FY11 Count	FY14 Count	FY15 Count
1	330	381	392
2	137	169	185
3	67	74	71
3+	58	71	104

7. <u>Reliance Upon Court-Ordered Treatment</u>

Early reports of the Monitor described an over-reliance on court-ordered treatment, both for hospital care and on an outpatient basis. Individuals were regularly committed to outpatient treatment in the absence of clear legal criteria and with court orders that were not specific with respect to what they were actually required to do. Nevertheless, if a mental health professional determined that such individuals were not being "amenable" to treatment, a warrant could be issued for them to be taken into custody and hospitalized—apparently, even if civil commitment criteria were not met.

Even before the long-overdue revisions in the State's mental health laws were finalized, the State took affirmative measures to correct such practices to ensure that the individuals who have SPMI that it serves are afforded treatment through the least restrictive means appropriate and that involuntary treatment was no longer used as a matter of routine or convenience, or to leverage access to services.

Figure-48 documents the State's significant progress in reducing its reliance on involuntary inpatient and outpatient services for people with SPMI. Between Fiscal Year 2011 (when implementation of the Agreement began) and Fiscal Year 2016, the number of individuals subject to involuntary outpatient commitment decreased by 63.3% (from 328 to 121). Aside from the striking percentage change, this finding is important on several levels. First of all, these decreases occurred without apparent adverse consequences and coincided with the State making significant expansions and improvements in its community-based services for people with SPMI. Secondly, as is discussed in the next section, during this period the State dramatically increased its community placement of individuals receiving long-term care at DPC—that is, individuals who tended to remain hospitalized because of the significant levels of their disability, their clinical complexity, their intense service needs, and often their persistent problematic behavior. Finally, the absolute numbers of people receiving court-ordered outpatient treatment reduced as the overall number of people being served in the public system increased, from 5,469 individuals receiving some sort of DSAMH service in Fiscal Year 11 to 7,892 individuals receiving such services in Fiscal Year 2015—a 44% increase.[35] Thus, reductions in outpatient commitments as a percentage of individuals with SPMI being served is even more significant than is represented in Figure-48.



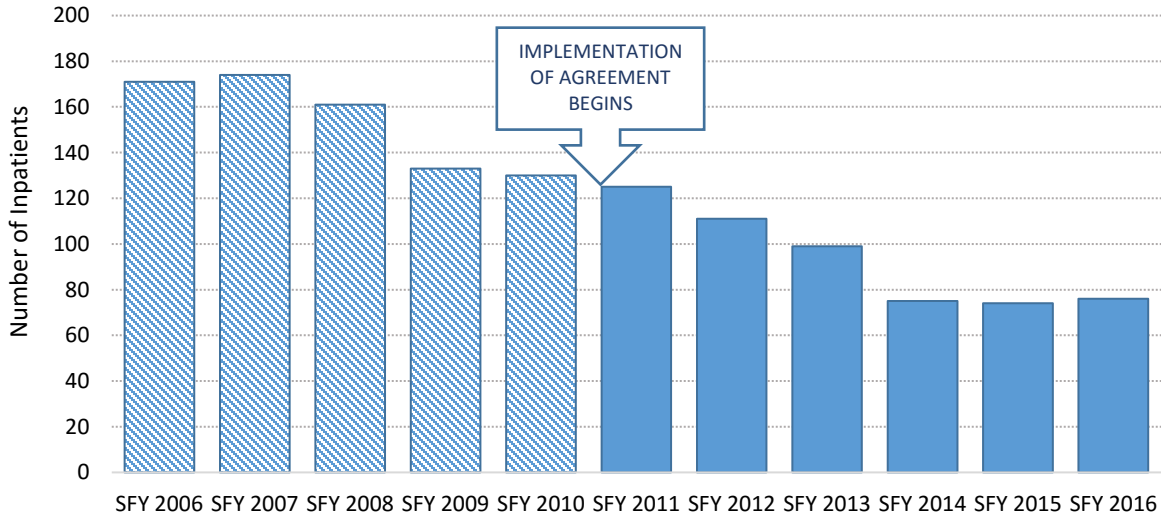
[35] University of Pennsylvania Service Use Rates

Involuntary hospitalizations have reduced, as well, but not as consistently or dramatically as the outpatient commitment rates. In Fiscal Year 2014, court ordered hospitalizations dropped by 41% relative to the year 2011, but the rate has since ticked up again and, as of Fiscal Year 2016, there is only a 6.1% reduction relative to the base year. The reasons for this are unclear, and given the State's interest in moving towards a more recovery-oriented, voluntary model of services, court-ordered hospitalization rates should warrant further analysis and action. Overall, however, the State has made significant progress in reducing its reliance on coercive treatment since implementation of the Agreement began.

8. DPC Census

The final quantitative measure relating to hospital bed-days used by the target population concerns the census at DPC. Figure-49 presents the average daily census for non-forensic patients at that facility for Fiscal Years 2006 through 2016. In Fiscal Year 2016, the average daily census for these individuals was 76, which represent a 55.6% reduction from 2006 and a 42% reduction since 2010, just prior to implementation of the Agreement.

Figure-49: Average Daily Census
DPC (Kent and Sussex Units)



The Agreement does not specifically require reductions in civil beds used at DPC, however, per the ADA, *Olmstead*, and other laws, it does require that individuals not be segregated in hospitals when they

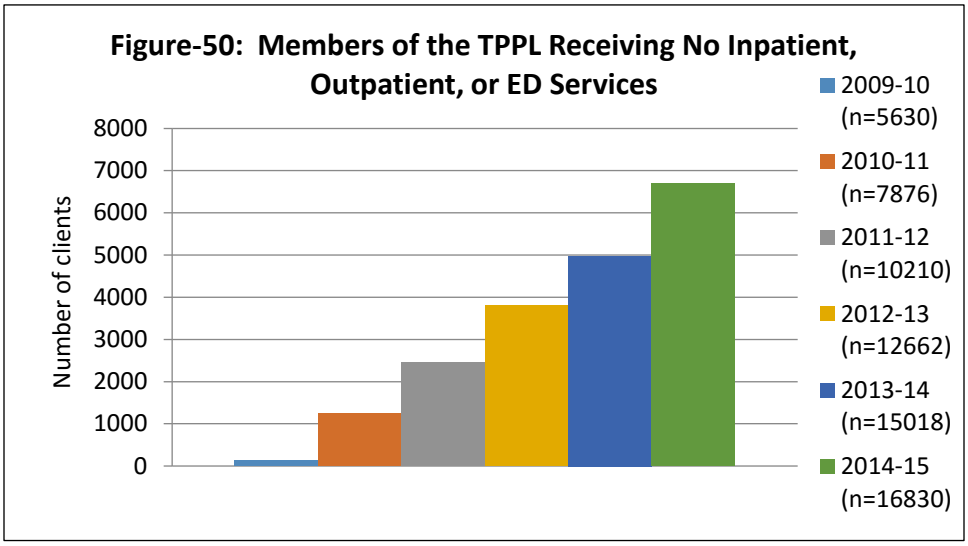
can be served in the community instead. The State's reduction in its Long Term Care bed use at DPC, as well as its downsizing the number of civil beds reflect its own determination of hospital bed needs in light of the array of community services that it has developed in accordance with the Agreement.

9. Addressing Diagnostic Issues

While individuals with SPMI can do well in the community (as is evidenced throughout this report), they generally require an array of community services and supports and, even with these supports, some may require brief re-hospitalizations. Recent data analyses from the University of Pennsylvania researchers show a surprising number of individuals who have been diagnosed with SPMI (often in association with hospitalization at an IMD), but then receive no subsequent treatment. Thus, although receiving hospital care ostensibly for SPMI, they are not referred for specialized mental health services through DSAMH, are not re-hospitalized, and do not receive generic mental health treatment through Medicaid providers. As was discussed earlier, several sources have suggested that there may be a significant population of individuals who are admitted to IMDs and misdiagnosed with SPMI when they actually have issues attendant to SUD. They may not be receiving appropriate services and, both for purposes of monitoring the Agreement and for the State's QA/PI activities that will extend beyond the Agreement, these individuals may be distorting important data relating to the needs and outcomes of individuals who do, in fact, have SPMI. Accordingly, the State initiated a study of single-episode hospital utilization, which is examining case records of a sample of individuals who have diagnoses of SPMI upon discharge from an IMD, but who have no further encounters with the system for extended periods of time.

The researchers report that about 24% of individuals diagnosed with SPMI and included on the TPPL have no treatment—inpatient, outpatient, or in an emergency department—in the two years following their initial identification. Furthermore, as is presented in Figure-50, over five years, these individuals account for almost 40% of the TPPL.[36]

[36] As was referenced earlier, the University of Pennsylvania and the State's criteria for inclusion on the TPPL vary somewhat.



Because these findings are not consistent with what would be expected for individuals who have SPMI, they are being used by the State to better understand how these individuals come to be admitted to IMDs and so diagnosed, and whether their service needs would be more appropriately addressed in other ways. A preliminary analysis of some individuals who were included on the TPPL in Fiscal Year 2011 (i.e., 2010-11 in the Figure above) and who had further treatment in the subsequent four years found that, co-occurring with SPMI diagnoses, 16.7% had primary discharge diagnoses of substance or alcohol use, 40% had these as secondary diagnoses, and 33.3% had these as a third discharge diagnoses. All of these factors support the importance of the State continuing to evaluate whether in fact these individuals are being appropriately diagnosed and served and the degree to which they are distorting hospitalization rates (and costs) and other outcomes that are being attributed to individuals with SPMI. The State's initial approach was to identify a sample of these individuals and to conduct thorough reviews of their clinical records within IMDs and, as may be applicable, with other service providers involved in their hospitalization. The intent was to clarify the trajectory leading individuals to hospital care and to begin to identify opportunities for diversion accordingly. Unfortunately, the State encountered difficulties in accessing the sample's clinical records; it is now exploring alternative strategies for this important effort.

As has been presented in this section, the State is carrying out extensive QA/PI activities and it is now doing so in a comprehensive way, using the Quality Control Steering Committee as its coordinating body. It is in Substantial Compliance with Section V.A of the Agreement (relating to a Quality Assurance and Performance Improvement System), as well as with Contracting (Section V.C), Quality Service Reviews (V.D), and Use of Data (V.E), which are closely related.

XIV. Risk Management

Substantial Compliance.

The ninth Monitor's report found the State to be in Partial Compliance with regard to Risk Management, but noted that it was taking steps to meet the requirements of the Agreement, as delineated in Section V.B. The State's essential problem was not so much that it lacks risk reduction programs, but that these functions are spread across various agencies and have not had a clear mechanism for integrated analysis. With respect to the Agreement, this has been a particular problem in the IMDs, where most of the hospital admissions of the target population occur. Reporting of complaints and adverse events in IMDs depends upon which agency has jurisdiction:

a. DSAMH receives reports for incidents which occur within an IMD for all individuals who receive services through DSAMH, as required by its contracts with community providers.

b. DMMA, via its contracted MCOs, receives reports for incidents which occur within an IMD for all individuals whose care is paid for by DMMA, as required by DMMA's contracts with the MCOs. DMMA also requires IMDs to provide incident reports directly to the Division for those individuals receiving Medicaid on a fee-for-service basis.

c. The Division of Long Term Care Residents Protection (DLTCRP) receives reports from IMDs related to incidents of abuse, neglect, mistreatment, or financial exploitation.

Delaware law requires IMDs to report such incidents to the DLTCRP, and dictates the DLTCRP's response.

d. The Department of Public Health (DPH) conducts hospital surveys on behalf of the federal Centers for Medicare and Medicaid Services and receives reports from IMDs when deaths occur due to the use of seclusion or restraint.

What the State lacked was a central clearinghouse where analyses of risks and adverse events affecting the target population could occur with the collective involvement of all responsible agencies and through which patterns of risk could be identified and addressed systemically. As was discussed in the Monitor's ninth report, in the Spring of 2016, the State put into effect memoranda of understanding affecting DSAMH, DMMA, DLTCRP, and DPH to ensure information-sharing relating to risk management. Furthermore, it is now convening Incident Review Meetings and Quality Control Steering Committee Meetings where risk management information relating to the target population is being consolidated and discussed with multi-agency input. The State has provided information and otherwise taken appropriate action in accordance with the recommendations regarding risk management that were included in the ninth Monitor's report. Finally, the Peer Review Subcommittee relating to Senate Bill 245, referenced early in this report, is charged with examining critical incident reports and root cause analyses relating to the target population.

In summary, the State has taken significant measures to unify its risk management processes relating to the target population and, given that oversight of these functions by the Peer Review Subcommittee is now enshrined in law, the improvements it has put into place are likely to continue. The State is rated as being in Substantial Compliance with the Agreement's Risk Management requirements.

D. Conclusion

This report has detailed the State of Delaware's successful efforts to meet the requirements of the Settlement Agreement it entered into with the U.S. Department of Justice in 2011 with the goal of promoting recovery and community integration of individuals with Serious and Persistent Mental Illness whom the State serves. The Monitor's finding that the State is in Substantial Compliance with the

Agreement is based not only upon the extensive data presented here, but also upon the self-reports of individuals served by the Delaware's public mental health system, such as those presented at the beginning of this report.

The Monitor's first report, issued January 30, 2012, included the following observation with regard to implementation of the Agreement:

> It is obviously too soon to predict the ultimate success of this endeavor. Stakeholders frequently remind the Monitor that they have witnessed a succession of prior investigations, failed reform efforts, short-sighted decisions and unfulfilled promises relating to Delaware's mental health system. They express genuine interest in the wellbeing of citizens with SPMI, tempered by some skepticism—perhaps, well-founded, given these experiences—as to the ultimate meaning of this newest "fix". Overwhelmingly, their concern is not so much about whether the positive outcomes required by the Settlement Agreement are achievable, but rather whether the effort will be sustained, whether innovation will be encouraged, whether bureaucratic loopholes and challenges will be corrected, and whether the resources needed to allow individuals with SPMI to live and thrive in integrated community settings will remain available over time.[37]

As is discussed throughout this report, there is ample evidence that, over these five years, the positive outcomes required by the Agreement (and the Americans with Disabilities Act, the *Olmstead* decision, and other laws on which the Agreement is based) have been significantly achieved for people with SPMI. Furthermore, the sustainability of these outcomes is supported by changes in the State's laws, administrative structures, reimbursement mechanisms, and service culture. It is also supported by a large, engaged, and vocal constituency including individuals with SPMI who are served by the system, their families and friends, Delaware's peer movement, providers, and other stakeholders. The State's now impressive data systems allow these constituents to examine service outcomes, to hold public programs accountable, and to recognize innovation and success. The State's services for people with

[37] Page 2.

SPMI are not flawless, but there is increasing unity and momentum regarding the goal of enabling these individuals to move from the social margins and to live as ordinary Delawareans as full members of their communities.

Robert Bernstein, Ph.D.

Court Monitor

APPENDICES

Appendix-A

Diagnoses Indicative of Serious and Persistent Mental Illness

used in Constructing the Target Priority Population List

P-Dx Cde Formal	P-Dx Literal
F20.81	Schizophreniform disorder
F20.9	Schizophrenia
F20.90	Schizophrenia
F21	Schizotypal personality disorder
F21.0	Schizotypal personality disorder
F21.00	Schizotypal personality disorder
F22	Delusional disorder
F22.0	Delusional disorder
F22.00	Delusional disorder
F25	Schizoaffective disorder, Bipolar type
F25.0	Schizoaffective disorder, Bipolar type
F25.00	Schizoaffective disorder, Bipolar type
F25.1	Schizoaffective disorder, Depressive type
F25.10	Schizoaffective disorder, Depressive type
F29	Unspecified schizophrenia spectrum and other psychotic disorder
F29.0	Unspecified schizophrenia spectrum and other psychotic disorder
F29.00	Unspecified schizophrenia spectrum and other psychotic disorder
F31	Bipolar I disorder, Current or most recent episode hypomanic
F31.0	Bipolar I disorder, Current or most recent episode hypomanic
F31.00	Bipolar I disorder, Current or most recent episode hypomanic
F31.11	Bipolar I disorder, Current or most recent episode manic, Mild
F31.12	Bipolar I disorder, Current or most recent episode manic, Moderate
F31.13	Bipolar I disorder, Current or most recent episode manic, Severe
F31.2	Bipolar I disorder, Current or most recent episode manic, With psychotic features
F31.20	Bipolar I disorder, Current or most recent episode manic, With psychotic features
F31.31	Bipolar I disorder, Current or most recent episode depressed, Mild
F31.32	Bipolar I disorder, Current or most recent episode depressed, Moderate
F31.4	Bipolar I disorder, Current or most recent episode depressed, Severe
F31.40	Bipolar I disorder, Current or most recent episode depressed, Severe
F31.5	Bipolar I disorder, Current or most recent episode depressed, With psychotic features
F31.50	Bipolar I disorder, Current or most recent episode depressed, With psychotic features
F31.73	Bipolar I disorder, Current or most recent episode manic, In partial remission
F31.74	Bipolar I disorder, Current or most recent episode manic, In full remission
F31.75	Bipolar I disorder, Current or most recent episode depressed, In partial remission
F31.76	Bipolar I disorder, Current or most recent episode depressed, In full remission
F31.81	Bipolar II disorder

F31.89	Other specified bipolar and related disorder
F31.9	Bipolar I disorder, Current or most recent episode hypomanic, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode manic, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode depressed, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode unspecified
F31.9	Unspecified bipolar and related disorder
F31.90	Bipolar disorder
F33.1	Major depressive disorder, Recurrent episode, Moderate
F33.10	Major depressive disorder, Recurrent episode, Moderate
F33.2	Major depressive disorder, Recurrent episode, Severe
F33.20	Major depressive disorder, Recurrent episode, Severe
F33.3	Major depressive disorder, Recurrent episode, With psychotic features
F33.30	Major depressive disorder, Recurrent episode, With psychotic features
F33.41	Major depressive disorder, Recurrent episode, In partial remission
F33.42	Major depressive disorder, Recurrent episode, In full remission
F33.9	Major depressive disorder, Recurrent episode, Unspecified
F33.90	Major depressive disorder, Recurrent episode, Unspecified
F60	Paranoid personality disorder
F60.0	Paranoid personality disorder
F60.00	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.10	Schizoid personality disorder
F60.3	Borderline personality disorder
F60.30	Borderline personality disorder

Appendix-B

Community Living Questionnaire

COMMUNITY LIVING QUESTIONNAIRE

To be Filled Out By The Community Service Provider when the client first enters the public system either through a referral from a hospital or from the EEU, and then to be filled out annually and included in the EEU packet and submitted to the EEU.

Client Name: _____ **Signature:** _____ **Date:** _____

Community Service Provider: _____ **Care Manager Name and Signature:** _____ _____

These questions are about things you would like considered when we think about you moving to your own place. We will talk about the neighborhood where you might live, the kind of housing you would like best, whether or not you want housemates, what kind of help you want and anything else that is important to you about where you live.

☐ I am adequately housed and not in need of a different location now. However, I have these concerns:

☐ Please see Housing Plan Assessment

1. What are your feelings about moving to your own place, either on your own or w/another person?			
1 ☐ I'm eager to get my own place	2 ☐ I have mixed feelings about getting my own place	3 ☐ I have some worries about living in my own place	4 ☐ I haven't given much thought to living in my own place
If you have some worries about moving into your own place, what are your concerns?			
How might we make things easier for you?			
Where were you living before you came here?			
When was the last time you lived in your own place?			

As we fill out this form together, let's be sure that we think about where you'd like to live and how we can take care of anything that you may be worried about.

2. How much choice would you like to have over the place you live?		
1 ☐ No choice at all	2 ☐ Some Choice	3 ☐ A great deal of choice

3. How much choice would you like to have over the neighborhood where you live?		
1 ☐ No choice at all	2 ☐ Some Choice	3 ☐ A great deal of choice

4. Please rate your community living choice, rating 3 as your top pick			
How much would you like to live…	Not at all	Somewhat	A lot
By yourself in your own apartment or house	☐	☐	☐
In a house or apartment with another person	☐	☐	☐
If you'd like to live with another person, do you have anyone in mind who you'd like as a housemate? ☐ No ☐ Yes	Name-	How do you know this person?	
Something different from either one of these	☐	☐	☐
If you have something different in mind, what would it be:			

5. How important is each of the following in making a choice about where you live?	Not important at all 1	Somewhat important 2	Very important 3
Location is near or with people you like?	☐	☐	☐

Who are some of these people?	How do you know them?	Where do they live?

Location is near your old neighborhood?	☐	☐	☐
Where is your old neighborhood?			

	Not important	Somewhat important	Very important
Location is near services, recreation and transportation?	☐	☐	☐
Safety of the neighborhood?	☐	☐	☐
You can move into this place right away—it's available now?	☐	☐	☐
Decorating and furnishing your home yourself	☐	☐	☐
Having a pet	☐	☐	☐
Having someone else to take care of repairs and maintenance	☐	☐	☐
Having a yard or garden	☐	☐	☐
Having children around the place you live	☐	☐	☐
Being able to have a car and parking	☐	☐	☐
What floor your place is on	☐	☐	☐
Having privacy	☐	☐	☐
Having people around that you can talk to	☐	☐	☐
Other things that are important to you:			

7. Do you need anything special to help you get around your house or apartment? Y / N

If yes, what kind of things do you need: ☐ No steps ☐ Wheelchair ramp ☐ Elevator ☐ Other

☐ Things to help you with seeing problems ☐ Things to help you with hearing problems

8. Using your own words, talk about the kind of help you might need to live in your own place with any the following:	Not Needed	Initial Assistance	Continuing Support
a. Preparing a meal	☐	☐	☐
b. Grocery shopping	☐	☐	☐
c. Doing other shopping	☐	☐	☐
d. Cleaning your living space	☐	☐	☐
e. Doing laundry	☐	☐	☐
f. Getting to appointments or work	☐	☐	☐
g. Walking up and down stairs	☐	☐	☐
h. Using the telephone	☐	☐	☐
i. Paying your bills	☐	☐	☐
j. Managing your money	☐	☐	☐
k. Taking medication	☐	☐	☐
l. Dealing with medical problems	☐	☐	☐
m. Getting dressed	☐	☐	☐
n. Taking a bath or shower	☐	☐	☐
o. Going to the bathroom	☐	☐	☐
p. Daily grooming	☐	☐	☐
q. Connecting with a religious group	☐	☐	☐
r. Getting in touch with family or friends	☐	☐	☐
s. Getting help to avoid feeling lonely	☐	☐	☐
t. Getting help finding hobbies or recreation	☐	☐	☐
u. Keeping away from drugs or alcohol	☐	☐	☐
v. Having a place that you can call any time of the day or night if you need help	☐	☐	☐
9. What other kind of help might you need in your own place?			
10. Is there anything else that's important about where and how you want to live after you move? ☐ No ☐ Yes Please give more examples about what else is important to you:			

If client was unable to collaborate to help complete the form by required time frame, date and initial subsequent attempts to complete:_____/_____/_____/_____/_____/_____/

√	Service or Support	Frequency (per mth)	Duration (months)	Provider	Barriers/Comments	N/A
	ADL					
	1. Grooming – hair, mouth care, bathing, shaving					
	2. Dressing					
	3. Feeding self					
√	**Service or Support**	**Frequency (per mth)**	**Duration (months)**	**Provider**	**Barriers/Comments**	N/A
	4. Bathing					
	5. Need of assistance for tub/shower					
	IADL					
	1. Cleaning/housekeeping chores					
	2. Laundry					
	3. Shopping					
	4. Transit mobility – bus					
	5. Basic money exchange					
	6. Meal/food preparation					
	7. Going to the store					
	8. Durable medical mobility equip. – walker, cane, wheelchair, etc					
	9. Adult Protective Services					
	10. Case Mgt – generic					
	11. Case Mgt – intensive					
	12. Coaching – shopping					
	13. Chore/companion/home maker					
	14. Congregate meals/senior center					
	15. Family training					
	Financial Management and Counseling					
	1. How to budget					

	2. Understanding guardianship or alternative payee					
	Hearing Challenges					
	Friendly Visitor					
	Telephone Reassurance					
	Habilitation/Supported Employment					
√	Service or Support	Frequency (per mth)	Duration (months)	Provider	Barriers/Comments	N/A
	Home Delivered Meals					
	Home Health Rehabilitation					
	1. Diabetes Mgmt					
	2. Psychotropic and/or medical Rx mgmt					
	3. Medical mgmt i.e. COPD, asthma, Hep C, early dementia					
	4. Speech					
	Home Modification					
	Home Repairs/Weatherization					
	Legal					
	Mental Health Counseling					
	Medicine Refills/Clinics					
	Occupational Therapy					
	1. In home OT services					
	2. OT consultant services					
	Peer Supports					
	Visual Challenges					
	Physical Therapy					
	1. In home PT services					
	2. Need for staff training					
	Rental Assistance					
	Respite – Individual					

	Respite – Caregiver					
	Substance Abuse Services					
	Transportation					
	Voc Rehab/Job Counseling					
	Wellness Checks/Health Maintenance					
√	Service or Support	Frequency (per mth)	Duration (months)	Provider	Barriers/Comments	N/A
	Referrals for Diabetes Management					
	Referrals for Smoking Cessation					

Clinical Team Review	**Printed Name**	**Signature**	**Date**
Person Served			
Nursing			
Psychiatry			
Social Work			
Psychology			
Occupational Therapy (when applicable)			
Physical Therapy (when applicable)			
Other/specify			
Community Provider			

If client was unable to collaborate to help complete the form by required time frame, date and initial subsequent attempts to complete:

_____/_____/_____/_____/_____/_____/_____/

Client / Guardian Signature _____ Date _____

Social Worker Signature_____ Date_____

Appendix-C

CRISP Interview

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Substance Abuse and Mental Health

CRISP Interview
Revised 12/3/14

Center for Mental Health Policy and Services Research
University of Pennsylvania

Interview Introduction

Hello, my name is _____. I am a peer specialist, which means that I have had personal experience with mental health problems in my lifetime. I am very pleased to be able to spend some time with you today. I am interviewing individuals who are in DPC, or have recently been in DPC who are planning to move into the community. We are attempting to find out what community services work the best for supporting individuals with mental health problems in the community. The information that I collect from you is confidential.

I will interview you today and contact you again in about 12 months to ask you for some updated information. If you decide to participate, myself or another peer specialist will follow-up and interview you annually for the next five years.

This interview will take about 30 minutes. Please let me know if you are uncomfortable with any of the questions or would prefer to not answer a specific question. I will stop the interview if you decide, for any reason, that you do not want to participate. Do you have any questions?

CRISP INTERVIEW FACE SHEET

Interviewer Completes

Interviewer Name _____

Consumer Name _____

Site Name _____

Interview Date |___|___|___|___|___|___|

Assessment

- ○ Baseline Assessment
- ○ 12-Month Reassessment
- ○ 24-Month Reassessment
- ○ 36-Month Reassessment
- ○ 48-Month Reassessment
- ○ 60-Month Reassessment

Assessment Not Completed

- ○ Client Refused Interview **Refusal Date** |___|___|___|___|___|___|

Consumer's reason for refusal _____

- ○ Client Unable to Communicate

Interviewer DOES NOT Complete

Consumer ID (MCI #) |___|___|___|___|___|___|___|___|___|___|___|

CRISP Site ID |___|___|___|___|___|___|___|___|___|___|

Scores

___ Functioning
___Satisfaction
___Physical Health
___Emotional Health
___Substance Use
___Perception of Care/Satisfaction
___Housing
___Criminal Justice Involvement
___Trauma
___IADL – *completed by provider staff*
___BPRS Symptom Severity – *completed by psychiatrist*

DPC discharge date

|___|___| / |___|___|___|___|
MONTH YEAR

Community Referral date

|___|___| / |___|___|___|___|

Community Placement date

|___|___| / |___|___|___|___|
MONTH YEAR

CRISP INTERVIEW

Physical Health

How would you rate your overall health right now?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor ○ Don't Know

○ Refused

Where do you receive your primary health care?

○ Community health clinic ○ Private provider in community ○ CRISP provider ○ ED (hospital)

○ Don't know ○ Refused

When did you last see your Primary Care Physician?

○ Within 30 days ○ Within 6 months ○ Within 2 yrs. ○ Over 2 yrs.

○ Don't know ○ Refused

Please indicate the answer that best describes your current health today.

Mobility

○ I have no problems walking about

○ I have some problems walking about

○ I am confined to bed

Self-Care

○ I have no problems with self-care

○ I have some problems washing and dressing myself

○ I am unable to wash or dress myself

Usual Activities

○ I have no problems with performing my usual activities (e.g. work, study, housework, family or leisure activities)

○ I have some problems with performing my usual activities

○ I am unable to perform my usual activities

Pain/Discomfort

○ I have no pain or discomfort

○ I have some pain or discomfort

○ I have extreme pain or discomfort

Anxiety/Depression

○ I am not anxious or depressed

○ I am moderately anxious or depressed

○ I am extremely anxious or depressed

Other Details about Physical Health:

_____

_____

_____

Mental Health

How well you were able to deal with your everyday life **during the past 30 days.** Please indicate your disagreement/agreement with each of the following statements.

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
1. I deal effectively with daily problems.	○	○	○	○	○	○	
2. I am able to control my life.	○	○	○	○	○	○	
3. I am able to deal with crisis.	○	○	○	○	○	○	
4. I am getting along with my family.	○	○	○	○	○	○	○
5. I do well in social situations.	○	○	○	○	○	○	
6. I do well in school and/or work.	○	○	○	○	○	○	○
7. My housing situation is satisfactory.	○	○	○	○	○	○	
8. My symptoms are not bothering me.	○	○	○	○	○	○	

For each question below, please indicate how often you had the following feelings in the **past 30 days.**

QUESTION	RESPONSE OPTIONS						
During the past 30 days, about how often did you feel …	**All of the Time**	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**	**REFUSED**	**DON'T KNOW**
1. nervous?	○	○	○	○	○	○	○
2. hopeless?	○	○	○	○	○	○	○
3. restless or fidgety?	○	○	○	○	○	○	○
4. so depressed that nothing could cheer you up?	○	○	○	○	○	○	○
5. that everything was an effort?	○	○	○	○	○	○	○
6. worthless?	○	○	○	○	○	○	○

Other Details about Mental Health:

_____

_____

_____

_____

Substance Use

The following questions relate to your experience with alcohol, cigarettes, and other drugs. Sometimes medications are prescribed by a doctor (like pain medications). I will only record prescription medications if you have taken them for reasons or in doses other than prescribed by your doctor.

QUESTION	RESPONSE OPTIONS					
In the past 30 days, how often have you used…	**Never**	**Once or Twice**	**Weekly**	**Daily or Almost Daily**	**REFUSED**	**DON'T KNOW**
1. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	○	○	○	○	○	○
2. alcoholic beverages (beer, wine, liquor, etc.)?	○	○	○	○	○	○
3. other drugs not prescribed by a doctor? (i.e. illegal drugs)	○	○	○	○	○	○
4. drugs prescribed by a doctor but misused?	○	○	○	○	○	○
5. over use of over-the-counter drugs such as sleeping aids or diet drugs?	○	○	○	○	○	○

Other Details about Substance Use:

_____

_____

_____

Trauma

Have you ever seen or experienced violence or trauma such as physical assault, psychological or sexual mistreatment, natural disaster, terrorism, or neglect?

○ Yes ○ No ○ Don't Know ○ Refused

Other Details about Trauma:

_____

_____

_____

Perception of Care/Satisfaction

Please tell me what you think about the services you received **during the past 30 days.**

STATEMENT	RESPONSE OPTIONS						
*Indicates key questions	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**Refused**	**Not Applicable**
1. *Staff here believe that I can grow, change and recover.*	○	○	○	○	○	○	
2. I felt free to complain.	○	○	○	○	○	○	
3. I was given information about my rights.	○	○	○	○	○	○	
4. Staff encouraged me to take responsibility for how I live my life.	○	○	○	○	○	○	
5. Staff told me what side effects to watch out for.	○	○	○	○	○	○	○
6. Staff respected my wishes about who is and who is not to be given information about my treatment. (i.e. staff members, family, friends)*	○	○	○	○	○	○	
7. Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○	○	
8. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	○	○	○	○	○	○	
9. *I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.)*	○	○	○	○	○	○	
10. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○	
11. I, not staff, decided my treatment goals.	○	○	○	○	○	○	
12. I like the services I received here.	○	○	○	○	○	○	
13. *If I had other choices, I would still get services from this agency.*	○	○	○	○	○	○	
14. I would recommend this agency to a friend or family member.	○	○	○	○	○	○	

Other Details about Perception/Satisfaction with Care:

Social Connectedness

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) **over the past 30 days.**

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
1. I am happy with the friendships I have.	○	○	○	○	○	○
2. I have people with whom I can do enjoyable things.	○	○	○	○	○	○
3. I feel I belong in my community.	○	○	○	○	○	○
4. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○

Other Details about Social Connectedness:

_____

_____

Housing

In the past 30 days how many …	Number of Nights/ Times	REFUSED	DON'T KNOW
1. nights have you been homeless?	_____	○	○
2. nights have you spent in a hospital for mental health care?	_____	○	○
3. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	_____	○	○
4. nights have you spent in correctional facility including jail, or prison?	_____	○	○

What housing/living environment would you prefer?	YES	NO	DON'T KNOW
5. Live in a place/home where staff are accessible 24 hrs/day, such as assisted living, supervised housing or group homes.	○	○	○
6. Live in a place such as transitional or group home, where staff/advocate help you with personal care needs, such as shopping, using the telephone, taking medicine, managing your money, doing your laundry, helping with medical care and other activities.	○	○	○
7. Live in a place where staff/advocate can help you make a smooth transition to your own housing, such as supervised living (staff are not available 24 hours/day).	○	○	○

8. Live in a place where staff provide activities and things to do in the community, such as bowling, movies, mall shopping, picnic, etc.	○	○	○
9. Live in a place by yourself where there is assistance with your physical health care only.	○	○	○
10. Live by yourself.	○	○	○
11. Live with your family.	○	○	○
12. Live with friends.	○	○	○

Other _____

Other Details about Housing: _____

_____

_____

_____

Crime and Criminal Justice Status

In the past year, how many times have you been arrested?

____# TIMES ○ REFUSED ○ DON'T KNOW

Other Details about Crime and Criminal Justice Status:

_____

_____

Interview Time: _____ (minutes)

Additional comments/thoughts that were not covered in the interview: