MEMO

To: Office of Management & Budget

From: Brian Hartman, on behalf of the following organizations:

Disabilities Law Program
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities

Subject: Division of Substance Abuse & Mental Health FY 12 Budget

Date: November 16, 2010

Please consider this memo a summary of the oral presentation of Brian J. Hartman, Esq. on behalf of the Disabilities Law Program ("DLP"), Developmental Disabilities Council ("DDC"), Governor's Advisory Council for Exceptional Citizens ("GACEC"), and the State Council for Persons with Disabilities ("SCPD"). We are addressing one (1) overarching aspect of DSAMH's budget, the urgent need to reverse the historical skewing of resources to institutional versus community programs.

In our March, 2010 DSAMH budget presentation to the JFC, we encouraged policymakers to consider the on-going fiscal imprudence of allocating a disproportionate amount of resources to an institutional setting. This is a chronic problem. In its 2007 report, the Governor's Task Force on DPC noted that "Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%."[1] This distorted allocation of funding remains in effect today. The FY11 budget allocates only 44% ($31,785.2 million) of the mental health budget to community support vs. 56% ($40.042.1 million) to DPC.[2] Of the 14,000+ clients served in DSAMH contract and state-operated programs, 56% of funds is spent on an institution serving roughly 200 individuals.

The most recent national statistics underscore the disparity. Last year the National Alliance on Mental Illness ("NAMI") issued a comprehensive report, "Grading the States 2009 Report Card". Delaware received a grade of "D" for community integration. Moreover, Delaware ranked 5th in the Nation in the number of psychiatric hospital beds per 1,000 adults with serious mental illness.[3]

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[1]Governor's Task Force on the Delaware Psychiatric Center, Final Report (December 18, 2007) at 49-50. [Attachment "A"] The Task Force was co-chaired by the State's former budget director, Pete Ross, and the current DHSS Secretary, Rita Landgraf.

[2]The relevant excerpt from the FY 12 budget bill (S.B. No. 310) is included as Attachment "B".

[3]Relevant excerpts from the report are included as Attachment "C".

The anomaly reinforced by the budget is that many Division clients unnecessarily spend years in DPC simply because there is a lack of funded community options. DPC "length of stay" statistics paint a compelling picture of Delawareans unnecessarily languishing in the Center. The Governor's Task Force report observed that "the average aggregate length of stay for residential adult patients at DPC in 2006 was 2,130 days (5.8 years) compared to the national average of 869 days (2.4 years).[4] This disparity has actually worsened since 2006. Last year, the average length of stay for residential DPC patients was 2,682 days, i.e., 7.34 years! Federal SAMHSA statistics are corroborative. For DPC patients who reach the threshold of 1 year in the facility, the average length of stay is 3,379 days (9.25 years), almost double the national average.[5]

The Department of Justice has now issued a compelling November 9, 2010 report which highlights the same concerns. It concludes that many DPC patients could be diverted or moved to community settings with proper planning and a major reallocation of resources. The Secretary is committed to effect significant reforms but is requesting flexibility in the Department's budget to accomplish such reforms. See November 12, 2010 News Journal article [Attachment "E"]. The News Journal has endorsed this approach as a prerequisite to effective change. [Attachment "F"]

Recommendations

The U.S. Department of Justice report is a "shot across the bow" which should serve as a catalyst for revamping Delaware's mental health system. The Department is aggressively enforcing the ADA's community integration mandate nationwide [Attachment "G"]. We recommend, unlike some states which have chosen to expend resources on defensive litigation, that Delaware recognize its obligations to stop "warehousing" its citizens and work collaboratively to reform the State's mental health system.

Delaware enjoys a committed and progressive DHSS Secretary, DSAMH Director, and provider network. We need to take advantage of their vision and expertise by honoring the Secretary's request for adoption of a more flexible budgetary model.

Thank you for your consideration of our comments.

Attachments F:pub\bjh\legislat\mhjfcfy11

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[4]Governor's Task Force on the Delaware Psychiatric Center Final Report (December 18, 2007) at p. 49. [Attachment "A"]

[5]SAMHSA Delaware 2008 Mental Health National Outcome Measures, Table 2. [Attachment "D"]

EXCERPT

Governor's Task Force On the Delaware Psychiatric Center

Final Report

December 18, 2007

Task Force Members:

Senator Margaret Rose Henry
Kevin Ann Huckshorn, R.N.; MSN,
Rita Landgraf (Co-Chair)
Representative Pam Maier
Dennis Rochford
Harold Rosen, M.D.
Peter Ross (Co-Chair)
Yvonne Stringfield, Ed.D; R.N.
Gary Wirt, Ed.D

Created by:

Executive Order 100
August 17, 2007

Staff:
Brian Posey; AARP
Lisa Schieffert, DHSS
Keith Warren, Office of the Governor
Andrea Summers, Office of Highway Safety, Dept. of Safety and Homeland Security

Attachment "A"

- **The Task Force recommends that a utilization review (UR) process be initiated that is managed by an independent community contractor not otherwise involved in the DSAMH system of care.** This UR process should mirror the kind of UR performed by other community hospitals and managed care insurers and would provide the state with daily reports regarding people admitted to DPC who no longer meet criteria for this level of care. The above recommendations should alleviate this scenario and would afford the state a comprehensive planning process, which is cost-effective and ensures that the appropriate level of care is provided.

- **For DPC to better reflect their actual length of stay, data needs to be analyzed based by patient population inclusive of Forensic Unit (Mitchell), Long Term Care Unit (Carvel), Acute Care Unit (K-3) and Intermediate Care Units (K-S).** The average aggregate length of stay for resident adult patients at DPC in 2006 was 2,130 days compared to the national average of 869 days. CMHS reports that in 2006 Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%.

III. Funding Considerations

A. National and Historical Perspective

As states steadily shift from a delivery system focused on inpatient services to one of community-based service, this movement has been reflected in their mental health budgets. A national study (NASMHPD Research Institute, 2005) shows dramatic changes in the allocation of total state mental health agency expenditures in the United States between 1993 and 2003. For example:

In 1993
--48% of mental health budget expenditures were allocated to state psychiatric hospital inpatient services
--49% of expenditures were allocated to community-based services

By 2002
--29% of expenditures were allocated to state psychiatric hospital inpatient services
--69% of expenditures were allocated to community-based services

Delaware's allocation of resources today is similar to that of the U.S. in 1993. In 2005, Delaware's spending on community-based services for the same time was 45%. It is difficult to know what Delaware's total community costs are as the state's Medicaid service costs are not included. It may be that with the addition of these Medicaid community mental health expenditures that DE's community funding is higher than 45%, which would change these ratios. Most states include Medicaid expenditures when reporting these costs.

- **The Task Force recommends that an explanation regarding why inpatient service costs are not being shared by Medicaid needs to be provided.** It should also be noted that the 45% of spending on community-based care includes funds to support the involuntary commitments to community psychiatric hospitals such as Rockford Center, Meadowwood and Dover Behavioral Health. The use of state general revenue funding for private psychiatric beds in the community needs to be reviewed. Medicaid generally pays the cost of psychiatric care when that care is provided in a general medical facility.

- **The Task Force recommends that all efforts need to be taken to access these federal dollars to help support these very expensive hospital beds.** Also, the actual per bed day costs need to be described in order to assure that the state is not over-paying for these beds. Costs per bed should reflect the costs paid by managed care providers for these same services for their covered populations.

B. Recent Delaware Budgetary Practices

- **The Task Force recommends that Delaware's budgetary allocations for community support services keep closer pace with the ongoing need, and that the community support service system receive inflationary increases to sustain their current level of services. The Task Force recommends a dedicated % of increase be provided to providers on an annual basis that is reflective of inflationary measures and/or the CPI. Between 2001 and 2007, private providers received less than 4% in contractual increases. During this same timeframe, the consumer price index increased by approximately 30%.** Rates for services, many of them set in 2001, have not be re-evaluated for increases. Providers have indicated this lack of increase has a direct impact on the delivery of service. Many have increased the number of individuals being served assigned to a staff member, resulting in a less intensive service for those with the most significant conditions. DE community mental health providers testified that they have not been able to provide cost of living increases for their employees for many years and that these same employees are still limited to mileage reimbursement that is almost 50% less than the federal rate. *Such erosion of community-based services can lead to increased use of unnecessary hospital care.* The non-state community providers have voiced that since 2001, community-based services have actually eroded. The Legislature last appropriated funds for group homes in the FY01 and FY02 budgets. Funds for supervised apartments were included in FY01, 02, 06, 07 and 08 budgets. As a result, *the Division's inventory of supported housing is limited to fourteen (14) group homes (serving 114 residents) and eight (8) supervised apartment programs. The combined capacity of the entire residential system is only two hundred nine (209) clients statewide.*

- The Task Force supports the movement of the 35 patients to community-based services and the dedicated funding associated with this movement to adequately support those transitioning from DPC to community. This movement will bring the community residential placements to 244 and hospital census 210, if average

S.B 310 (FY12 BUDGET)

Year ending June 30, 2011

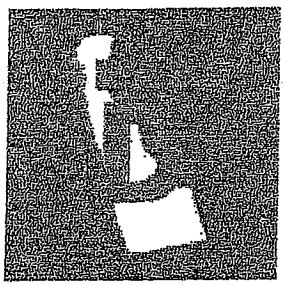
(35-00-00) DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Personnel				$ Program		$ Line Item	
NSF	ASF	GF		ASF	GF	ASF	GF
4.0	7.0	49.0	(-10) Director's Office/Support Services	1,601.6	3,722.7		
233.7	47.0	268.3	(-20) Community Health	35,035.0	23,870.2		
1.0		8.0	(-30) Emergency Medical Services	200.0	1,198.4		
	1.0	498.1	(-40) Delaware Hospital for the Chronically Ill	1,663.4	30,491.9		
		154.8	(-50) Emily Bissell	144.4	10,372.8		
		131.0	(-60) Governor Bacon	25.0	8,260.0		
238.7	55.0	1,109.2	TOTAL -- Internal Program Units	38,669.4	77,916.0		
			(35-06-00) Substance Abuse and Mental Health				
4.8	1.0	684.4	Personnel Costs			299.0	45,365.1
			Travel				6.9
			Contractual Services			1,569.9	28,760.8
			Energy				1,695.9
			Supplies and Materials			300.6	4,187.7
			Capital Outlay			9.0	184.0
			Tobacco Fund:				
			Contractual Services			142.2	
			Transitional Housing for Detoxification			177.1	
			Heroin Residential Program			412.0	
			Delaware School Study			28.7	
			Limen House			60.3	
			Other Items:				
	1.0		Medicare Part D			1,119.0	
			TEFRA			100.0	
			DPC Disproportionate Share			1,050.0	
			DPC Industries				38.1
			DOC Assessments			655.0	
			Clinical Care				277.5
			Kent/Sussex Detox Center			300.0	
			CMH Group Homes				6,901.3
4.8	2.0	684.4	**TOTAL -- Substance Abuse and Mental Health**			6,222.8	87,417.3
2.0		62.0	(-10) Administration	60.0	4,405.9		
1.0		94.0	(-20) Community Mental Health	1,605.0	31,785.2		
0.8	1.0	503.4	(-30) Delaware Psychiatric Center	2,196.6	40,042.1		
1.0	1.0	25.0	(-40) Substance Abuse	2,361.2	11,184.1		
4.8	2.0	684.4	TOTAL -- Internal Program Units	6,222.8	87,417.3		

Attachment "B"

the States

EXCERPT



Grading the States 2009 Report Card: Delaware

In 2006, Delaware's mental health care system received a grade of C. Three years later the grade has dropped to a D, in part because of the lack of consumer-run programs and limited efforts to reduce the criminalization of people with mental illness. Full narrative (PDF).

Grades by Category (PDF) Detailed Score Card

I. Health Promotion and Measurement: D Grade — 25% of Total
Basic measures, such as the number of programs delivering evidence-based practices, emergency room wait-times, and the quantity of psychiatric beds by setting.

II. Financing & Core Treatment/Recovery Services: D Grade — 45% of Total
A variety of financing measures, such as whether Medicaid reimburses providers for all, or part of evidence-based practices; and more.

III. Consumer & Family Empowerment: F Grade — 15% of Total
Includes measures such as consumer and family access to essential information from the state, promotion of consumer-run programs, and family and peer education and support.

IV. Community Integration and Social Inclusion: D Grade — 15% of Total
Includes activities that require collaboration among state mental health agencies and other state agencies and systems.

Innovations

- New state leadership
- Mobile crisis intervention teams
- Integrated dual diagnosis treatment

Urgent Needs

- Implement state hospital investigation recommendations
- Supportive housing
- Consumer-run programs
- Jail and prison reentry programs and CIT

Additional Information and Resources

Attachment "C"

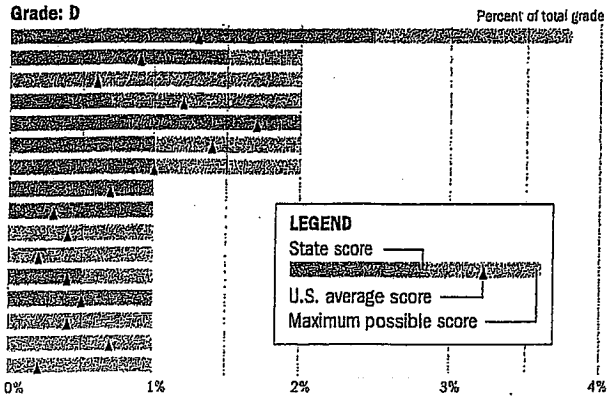
NAMI Score Card: DELAWARE

Grade: D

Category I: Health Promotion & Measurement

Grade: D

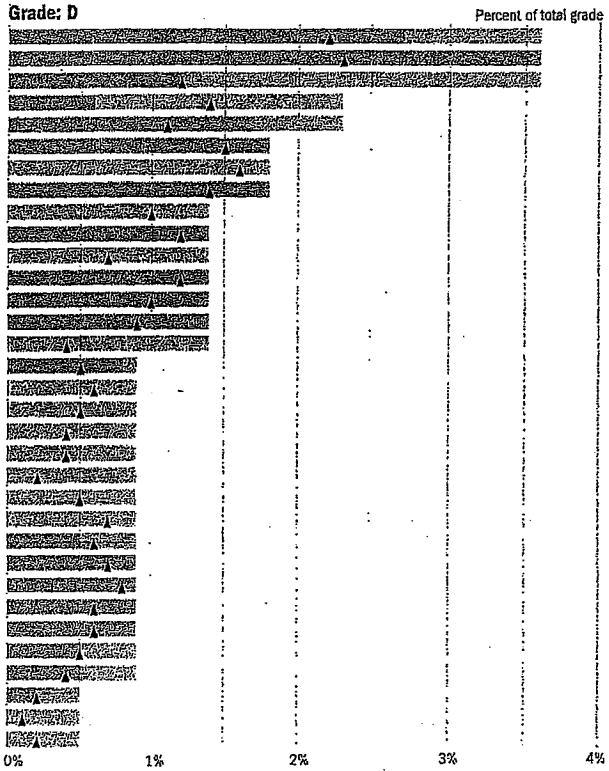
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

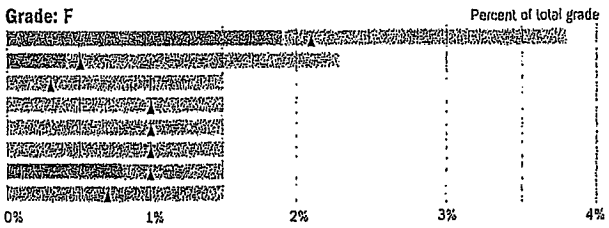
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

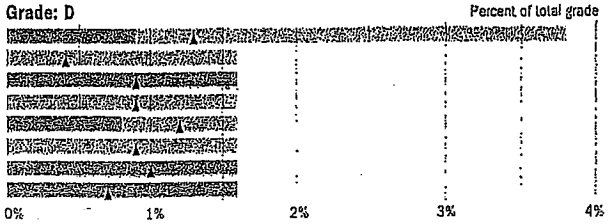
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



On the inpatient side, NAMI's review of data on psychiatric beds from the American Hospital Association's annual survey reveals that there are about 113,988 psychiatric beds for adults across the country (see Table 3.3).[24] This is down from an estimated 126,849 beds in 2000, and 197,139 beds in 1990.[25]

Looking at the availability of beds per capita, there are 10.8 beds per 1,000 adults with serious mental illness. Across states this ranges from more than 15 beds per 1,000 adults with serious mental illness (in DC, New Jersey, Mississippi, New York, Delaware, and Nebraska) to fewer than eight (in Arizona, Florida, Rhode Island, Michigan, Nevada, South Carolina, Montana, and Ohio).[26]

As with ACT, there is little consensus on the minimum number of psychiatric inpatient beds communities should have available. One recent study suggests a minimum of 50 public psychiatric beds per 100,000 residents (which translates into roughly 9.3 beds per 1,000 adults with serious mental illness).[27] But even this suggested minimum threshold assumes that effective community-based services and assisted outpatient treatment programs are available, which is not the case.

Furthermore, NAMI's estimates include private psychiatric hospital beds (about 16 percent of the total) and forensic beds (i.e., beds for individuals who are awaiting trial, determined by the court to be incompetent to proceed to trial, or who are found not guilty by reason of insanity). In some states, such as California, the vast majority of state public psychiatric beds are forensic beds, meaning very few "civil" beds are available.

States must have an adequate mental health workforce to deliver critical services. Analyses of the mental health workforce by the Sheps Center document significant shortages across the country: while only one in five counties (18 percent) has an unmet need for nonprescribers, nearly every county (96 percent) has an unmet need for prescribers. In examining and scoring workforce availability, NAMI ranked states according to the severity of their mental health workforce shortage and divided them into four equal groups (or quartiles). States with the highest shortages got the lowest score for "workforce availability" and vice versa. With 96 percent of all counties experiencing prescriber shortages, it is clear that even states in the top quartile for workforce availability are still experiencing shortages.[28]

Where can innovative practices be found?

- Rhode Island has expanded its ACT program with the addition of RI ACT II—a less resource-intensive model for individuals who do not need the full level of ACT services. Ohio funds a forensic Assertive Community Treatment (F-ACT) team that serves people with serious mental illness upon release from prison.
- The Georgia Crisis and Access Line (GCAL) is an innovative mechanism for tracking available psychiatric beds. A toll-free, 24/7 phone service staffed by licensed clinicians who can make appointments anywhere in the state, GCAL tracks (in real time) the state's psychiatric bed capacity and works with emergency departments across the state to ensure people in need have access to available beds.

Finding #3: States are Not Ensuring their Service Delivery is Culturally Competent

As noted in Chapter 1, research confirms that people from minority racial and ethnic communities have less access to mental health services, are less likely to receive these services, and often receive poor quality care in treatment.

[23] Arizona, Arkansas, Georgia, Iowa, Kentucky, Louisiana, Missouri, Nevada, New Mexico, Tennessee, Utah, Vermont, and Washington (fewer than three per thousand) and Alaska, Mississippi, Kansas, North Dakota, and Wyoming (no ACT or ACT teams reported).

[24] The AHA surveys all hospitals in the United States, and identifies these hospitals from multiple sources including state hospital associations, the Joint Commission, and the Centers for Medicare and Medicaid Services. Because their database includes information on the total number of staffed beds *even for hospitals that do not respond to their survey*, we are confident that the majority of the beds in state psychiatric hospitals are captured in their data. The data also include inpatient psychiatric beds in other state- and county-owned hospitals and non-profit and investor-owned community-based hospitals.

[25] None of these figures include beds in federal (VA and other) hospitals, of which there were about 4,700 in FY 2007. Estimates for 2000 and 1990 are from Table 19.2 in Ronald W. Manderscheid and Joyce T. Berry (eds.), *Mental Health, United States, 2004* (Rockville, MD: Substance Abuse and Mental Health Services Administration, DHHS Pub No. (SMA)-06-4195, 2006). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4195/chp19table2.asp.

[26] For scoring purposes, NAMI looked at the distribution across all states of adult inpatient psychiatric beds (per 1,000 adults with serious mental illness) and divided states into four equal groups (or quartiles). States in the top-most quartile (with the most beds per capita) were: DC, New Jersey, Mississippi, New York, Delaware, Nebraska, Connecticut, Massachusetts, Wyoming, Missouri, South Dakota, Maryland, and North Dakota. States in the bottom-most quartile (with the fewest beds per capita) were: Colorado, Texas, Vermont, Oregon, Washington, Ohio, Montana, South Carolina, Nevada, Michigan, Rhode Island, Florida, and Arizona.

[27] E. Fuller Torrey et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons* (Arlington, VA: Treatment Advocacy Center, 2008). This assumes an overall prevalence rate for serious mental illness of 5.4 percent.

[28] States with the most severe shortages are: Alabama, Arkansas, Idaho, Indiana, Iowa, Mississippi, Nebraska, Nevada, South Dakota, Texas, Utah, West Virginia, and Wyoming. States with the least severe shortages (relative to other states) are: California, Connecticut, DC, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Virginia.

Table 3.3 Grading the States 2009: Inpatient Psychiatric Beds in US Hospitals in FY 2007 (1)

State	State & Local Psychiatric Hospital Beds	Other State & Local Government Hospital Beds	Non-Government & Not-for-Profit Hospital Beds	Non-Government & Investor Owned Hospital Beds
Total (All States)	53,857	8,078	34,133	17,920
District of Columbia (DC)	817	0	131	104
New Jersey	3,685	127	1,747	210
Mississippi	1,553	225	148	568
New York	6,071	1,628	3,547	407
Delaware	323	0	45	92
Nebraska	716	0	259	0
Connecticut	777	25	810	0
Massachusetts	897	247	1,300	598
Wyoming	166	31	0	86
Missouri	1,342	72	983	702
South Dakota	244	0	176	0
Maryland	1,230	0	1,157	25
North Dakota	140	0	150	34
Pennsylvania	2,214	0	2,785	971
Kansas	692	128	337	0
Virginia	1,593	132	516	860
Hawaii	202	28	151	0
Indiana	1,172	201	886	386
New Hampshire	224	0	182	84
Alabama	990	399	107	584
Minnesota	1,147	134	581	0
Louisiana	874	285	188	675
Wisconsin	1,225	0	813	0
Idaho	215	63	70	237
Oklahoma	450	77	653	402
Georgia	2,539	129	610	462
Illinois	1,830	56	1,892	649
Tennessee	972	59	678	857
West Virginia	240	26	404	147
Maine	152	0	359	0
Kentucky	535	32	695	463
Utah	449	114	80	140
North Carolina	1,611	382	770	413
New Mexico	357	10	10	302
Iowa	223	210	542	0
Alaska	80	12	49	74
Arkansas	202	26	481	348
California	4,885	1,521	2,070	1,815
Colorado	860	53	300	140
Texas	3,108	275	1,270	2,410
Vermont	54	0	137	0
Oregon	739	31	349	0
Washington	1,216	105	342	115
Ohio	1,420	134	1,560	206
Montana	214	0	92	0
South Carolina	506	179	191	444
Nevada	401	0	18	257
Michigan	625	101	1,625	307
Rhode Island	0	0	282	0
Florida	1,342	622	1,235	1,261
Arizona	338	199	370	85

Notes: (1) Excludes all children's hospitals. Data represent "staffed beds," beds regularly available (those set up and staffed for use) within the reporting period.
(2) Estimates developed by Charles E. Holzer, III, Ph.D. of the University of Texas Medical Branch and Hoang T. Nguyen, Ph.D. of LifeStat LLC (see http://psy.utmb.edu/).

Source: FY 2007 AHA Annual Survey Database. Health Forum, an American Hospital Association affiliate, 2008. Reported prepared by AHA Resource Center, November 2008.

All Non-Federal Hospital Beds	Number of Adults with Serious Mental Illness (SMI), FY 2007 (2)	Non-Federal Psych. Beds Per 1,000 Adults SMI	Non-Federal Psych. Beds Per 1,000 Adults SMI—Rank	Federal Government Hospital Beds	Federal & Non-Federal Hospital Beds
113,988	10,590,429	10.8		4,660	118,648
1,052	22,811	46.1	1	0	1,052
5,769	258,617	22.3	2	0	5,769
2,494	125,269	19.9	3	0	2,494
11,653	672,924	17.3	4	490	12,143
460	28,652	16.1	5	0	460
975	60,744	16.1	6	0	975
1,612	108,730	14.8	7	0	1,612
3,042	210,815	14.4	8	732	3,774
283	19,733	14.3	9	203	486
3,099	222,596	13.9	10	106	3,205
420	30,351	13.8	11	15	435
2,412	175,173	13.8	12	116	2,528
324	24,131	13.4	13	0	324
5,970	448,455	13.3	14	175	6,145
1,157	95,110	12.2	15	125	1,282
3,101	261,959	11.8	16	22	3,123
381	32,435	11.7	17	27	408
2,645	226,713	11.7	18	0	2,645
490	42,818	11.4	19	0	490
2,080	186,541	11.2	20	411	2,491
1,862	167,810	11.1	21	388	2,250
2,022	182,593	11.1	22	82	2,104
2,038	188,057	10.8	23	18	2,056
585	54,375	10.8	24	0	585
1,582	147,343	10.7	25	47	1,629
3,740	348,789	10.7	26	87	3,827
4,427	420,841	10.5	27	165	4,592
2,566	246,003	10.4	28	32	2,598
817	81,214	10.1	29	0	817
511	51,248	10.0	30	16	527
1,725	181,441	9.5	31	19	1,744
783	82,362	9.5	32	21	804
3,176	334,855	9.5	33	96	3,272
679	71,674	9.5	34	30	709
975	104,922	9.3	35	21	996
215	23,650	9.1	36	0	215
1,057	116,435	9.1	37	73	1,130
10,291	1,180,000	8.7	38	28	10,319
1,353	157,828	8.6	39	8	1,361
7,063	832,795	8.5	40	0	7,063
191	22,712	8.4	41	10	201
1,119	137,345	8.1	42	0	1,119
1,778	218,585	8.1	43	184	1,962
3,320	418,207	7.9	44	370	3,690
306	38,961	7.9	45	0	306
1,320	170,022	7.8	46	15	1,335
676	88,540	7.6	47	42	718
2,658	348,154	7.6	48	412	3,070
282	37,739	7.5	49	17	299
4,460	660,443	6.8	50	31	4,491
992	220,909	4.5	51	26	1,018

Delaware 2008 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	6,332,983	10.80	20.69	58
Community Utilization per 1,000 population	5,639,738	9.37	19.15	56
State Hospital Utilization per 1,000 population	173,307	0.61	0.59	51
Other Psychiatric Inpatient Utilization per 1,000	383,904	1.34	1.51	40

Adult Employment Status	U.S.	State	U.S. Rate	States
Employment Status (percent in Labor Force)	679,084	34%	39%	56
Employment Status (percent with Employment Data)	679,084	24%	21%	56

Adult Consumer Survey measures	State	U.S. Rate	States
Positive About Outcomes	71%	72%	54

Child/Family Consumer Survey measures	State	U.S. Rate	States
Positive About Outcomes	82%	64%	54

Readmission Rates: (Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	13,771	10.5%	9.3%	48
State Hospital Readmissions: 180 Days	31,720	25.9%	21.3%	49
State Hospital Readmissions: 30 Days: Adults	12,519	10.5%	9.4%	47
State Hospital Readmissions: 180 Days: Adults	29,096	25.9%	21.8%	47
State Hospital Readmissions: 30 Days: Children	1,228	-	8.2%	38
State Hospital Readmissions: 180 Days: Children	2,568	-	17.1%	43

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	3,666,906	88.8%	80.8%	52
Homeless/Shelter	133,656	0.5%	2.9%	50
Jail/Correctional Facility	90,587	1.5%	2.0%	49

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	65,797	5.9%	3%	34
Supported Employment	40,387	4.4%	2%	41
Assertive Community Treatment	58,502	13.4%	2%	40
Family PsychoEducation	25,127	3.87%	2%	19
Dual Diagnosis Treatment	46,706	5.38%	4%	25
Illness Self Management	147,089	30.55%	9%	22
Medications Management	253,414	-	23%	17

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	16,291	1.0%	2%	28
Multi Systemic Therapy	8,126	-	1%	21
Functional Family Therapy	7,027	-	2%	14

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	78%	73%	51
Child/Family Improved Social Connectedness	-	86%	49

Attachment "D"

APPROPRIATENESS DOMAIN: TABLE 2: Length of Stay (LOS) in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers, FY 2008

STATE: Delaware

State Hospitals	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	125	40	81	53	1,088	749	5
Children	-	-	-	-	-	-	72	52	66	55	277	259	35
Adults	299	21	59	19	3,379	1,588	160	46	106	77	1,731	1,053	50
NA	-	-	-	-	-	-	17	3	13	14	40	30	1

Other Inpatient	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	14	7	13	7	140	136	4
Children	9	7	9	7	-	-	12	8	23	19	352	366	24
Adults	8	6	8	6	373	373	47	9	32	26	432	406	33
NA	-	-	-	-	-	-	1	1	0	-	-	-	1

Residential Treatment Centers	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	104	99	55	51	204	185	2
Children	197	175	175	172	484	472	171	144	126	119	468	500	28
Adults	1,018	687	160	123	1,505	966	300	201	94	83	802	666	19
NA	-	-	-	-	-	-	11	11	-	-	-	-	-

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS/DIG Table 6.

State Notes:

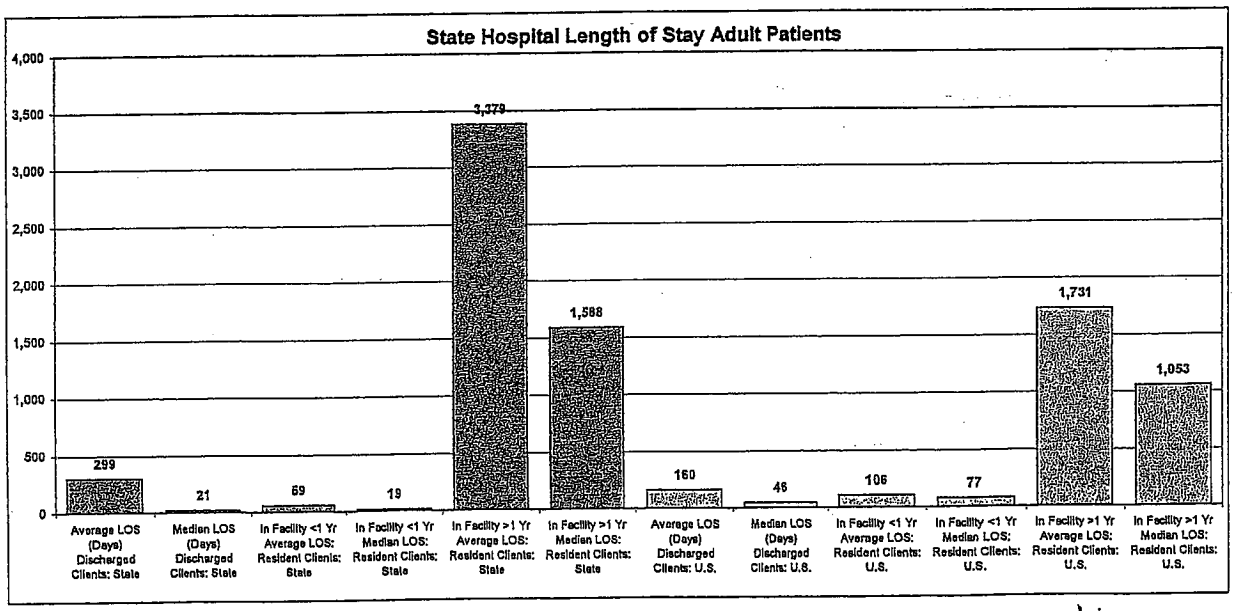
State Hospital None

Other Inpatient None

Residential Treatment Centers None

Community Programs None

Overall There is minor duplication between children and adult 18 year old consumers.



delawareonline

Delaware Psychiatric Center: We can't fix it alone, Landgraf says

Cooperation of lawmakers, unions key, she says

By SEAN O'SULLIVAN • The News Journal • November 12, 2010

The state can reform the Delaware Psychiatric Center to meet standards demanded by federal civil rights officials in a report released this week, but it will require the cooperation of the Delaware General Assembly and state employee unions, Delaware Health and Social Services Secretary Rita Landgraf said Thursday.

At least two state legislators also said they are willing to consider the budget flexibility that Landgraf said she needs, with one, Helene Keeley, D-Wilmington North, saying Landgraf's proposals seem "100 percent right on the money."

A nonprofit provider of community-based services – that likely will be called on by the state to helped meet federal demands – praised Landgraf's outline and said it could be ready in as little as 90 days to begin accepting additional patients from DPC if the proper funding and support is in place.

This is all in response to a 21-page letter from the U.S. Department of Justice's Civil Rights Division released Wednesday that summarizes a three-year investigation of the psychiatric center – started after a 2007 report in The News Journal about abuses at DPC – and concludes that the psychiatric hospital continues to unnecessarily warehouse the mentally ill instead of offering individual screening and treatment in a community setting.

Failure to reach an agreement with federal officials to correct the deficiencies could result in a civil r ights lawsuit against Delaware, the letter indicated.

Landgraf said she can make some changes without outside help, but added she will need the cooperation of Delaware legislators to grant her more flexibility in her budget. Currently, money is tied to the institution and the program – with some $42 million set aside to operate DPC's hospital facilities and $60 million earmarked for community programs, she said.

But Landgraf said she would like to see a more flexible model that ties funding to individual patients, similar to what is being done in states like Virginia, Arizona and Vermont. This allows dollars to ebb and flow with the needs of treatment, either in the hospital – where costs are higher – or in a community setting like a group home – where costs are lower.

At least 70 percent of the 170 non-criminal patients currently at DPC "could be and have a right to be living in community settings with appropriate services and supports," the federal report said.

This is where Landgraf would like to see some of DPC's work force and resources moved. "I value my work force, but we need to figure out how to utilize the work force differently," she said.

What Landgraf and federal officials would like to see is more of what is taking place at a group home operated by the nonprofit Connections Community Support Programs Inc. in Llangollen Estates, near New Castle. Five residents, ages 25 to 70, live with around-the-clock staff at the home.

Every morning, two of the five residents get on a DART Paratransit bus and head off to jobs.

The other residents, who are older or have more intensive medical needs, are allowed to follow their own pursuits, said Chris Devaney, chief operating

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Attachment "E"

officer at Connections. On Thursday, some played Nintendo Wii golf while one focused on writing, he said.

Landgraf said this shift of patients from DPC to the community could save the state money in the long run because it costs about $100,000 less on average to house someone in the community rather than the hospital.

Catherine McKay, president and CEO of Connections, said the savings could be even greater, depending on the patients and their needs.

If she receives the budgetary flexibility, Landgraf would then need cooperation from the unions that represent the 505 state employees at DPC to "reallocate" them from jobs at the hospital to nonprofit providers, like Connections.

Landgraf did not say Thursday how many or what percentage of DPC employees would need to be moved.

Michael A. Begatto, **executive director** of the American Federation of State, County and Municipal Employees Council 81, which represents most state employees, could not be reached for comment Thursday.

Such a shift of employees has been done before in Delaware and at DPC.

McKay said that in the 1980s, when Delaware first set about moving patients into community settings, the state's contract with a predecessor of Connections required that state employees whose jobs were being eliminated be given the first "right of refusal" for all new jobs created by the contract.

Rep. Greg Lavelle, R-Sharpley, said he will certainly be willing to hear out Landgraf on her plans. Lavelle said he hopes this is a sign that the Markell administration is taking a different approach to DPC than the Minner administration, which Lavelle said "just stuck their heads in the sand."

Keeley thinks the department and the unions could work together on the issue. "As long as they [union members] are well informed and are sitting at the table when the decisions are being made, it may not be as difficult as many think," she said.

McKay warned that Landgraf's proposal would work only if the state properly funds the community programs.

"Since 2002, community programs have been cut or held stable," McKay said, adding that underfunding of community programs was one issue raised in the federal letter to the state.

Landgraf said there is some tension from the threat of a lawsuit by federal officials, but said that may present a moment of opportunity for reform.

"Reform usually doesn't happen in good times," she said, adding it often takes a force, like litigation, to bring it about. "I would like, as a public servant, to do it without litigation. I don't want to be caught up in other costs," she said. "We can do this. It is a matter of political will with all of us."

Contact Sean O'Sullivan at 324-2777 or sosullivan@delawareonline.com.

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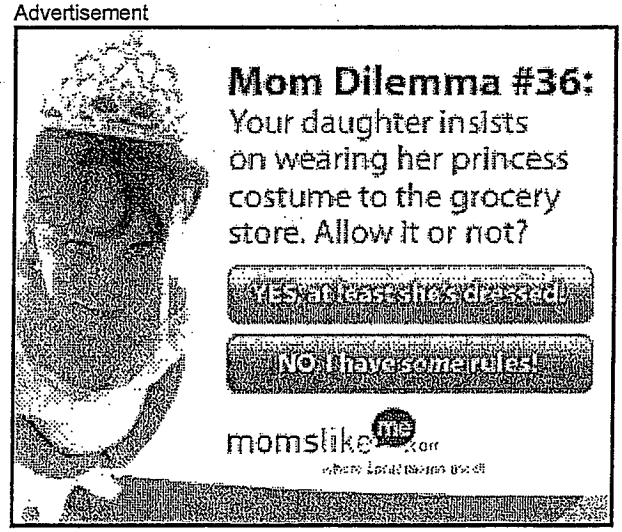

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delawareonline

Aiding psychiatric patients must be joint effort

November 12, 2010

This week's highly critical federal report on the state's "warehousing" of the mentally ill is another jolting reminder of the continuing problem of abuse and delay at the Delaware Psychiatric Center.

The report details how continuing violations and threats to the health and safety of the patients are the result of layers of bureaucracy that hamstring improvement efforts.

The report's authors agree with the state Department of Health and Social Services that better patient care and cost savings can come from more community-based placements.

The impediments to this change must be removed quickly, not just to avoid action by the federal government, but mostly to improve the lives of the hospital's patients.

The Markell administration has made some progress since the last federal investigation, but more needs to be done.

This is more than just an administration problem. The state's legislators, whose votes determine the DHSS budget, must do their part to make sure genuine reform takes place.

But the report and comments from officials indicate the challenge goes beyond budgets. A large problem is the hospital's culture. Bureaucratic layers insulate some employees from oversight and thwart change. Despite the acknowledged need to shift to community-based homes or the patients, too many people have a stake in keeping a large, central facility in operation.

That bureaucratic block must be broken. The General Assembly must be behind efforts like that to improve the welfare of the patients.

Moving the patients who should be out of the institution and in community homes requires a thorough, open transition that involves the entire community. It would be counterproductive to solve the problem of hospital culture only to be stymied by a resistant, suspicious community.

The burden of providing humane care must be shared by all of us.

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Attachment "F"

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KAISER HEALTH NEWS

Justice Dept. Pushes For Services To Move Patients Out Of Mental Hospitals

TOPICS: MENTAL HEALTH, STATES

By ANDY MILLER

OCT 21, 2010

ATLANTA – A sweeping agreement this week between the Justice Department and the state of Georgia highlights an aggressive new campaign by the Obama administration to ensure that people with mental illness and developmental disabilities can get services in their communities and not be forced to live in institutions.

The settlement, announced Tuesday, will be used "as a template for our enforcement efforts across the country,'" said Thomas Perez, assistant attorney general for the Civil Rights Division at Justice, in a statement announcing the accord.

The agreement ends three years of legal wrangling over Georgia's mental health system. National consumer advocacy organizations called the Georgia settlement unprecedented, with Curt Decker, executive director of the National Disability Rights Network saying in an interview that the agreement "sends a message to the rest of the country."

The Justice Department action demonstrates broader enforcement of the landmark 1999 Olmstead decision by the Supreme Court. The court in Olmstead – also a Georgia case -- ruled that under the Americans With Disabilities Act, unnecessary institutionalization of people with disabilities is a form of discrimination.

The action follows decisions by Justice to file briefs and join Olmstead-related lawsuits in several states, including New York, North Carolina, Arkansas, California and Illinois. "We will continue to aggressively enforce the law, and we hope other states will follow Georgia's example," Perez said.

As part of the accord, Georgia agreed to specific targets for creating housing aid and community treatment for people with disabilities, who in the past have often cycled in and out of the state's long-troubled psychiatric hospitals. The state said it will set aside $15 million in the current fiscal year and $62 million next year to make the improvements.

The state agreed to:

Attachment "G"

-- End all admissions of people with developmental disabilities to the state hospitals by July 2011.

-- Move people with developmental disabilities out of hospitals to community settings by July 2015.

-- Establish community services, including supported housing, for about 9,000 people with mental illness. These individuals, Perez said, "currently receive services in the state hospitals, are frequently readmitted to state hospitals, are frequently seen in emergency rooms, are chronically homeless or are being released from jails or prisons.'"

-- Create community support teams and crisis intervention teams to help people with developmental disabilities and mental illness avoid hospitalization.

Georgia Gov. Sonny Perdue said the agreement "moves us towards our common goals of recovery and independence for people with mental illness and developmental disabilities."

Lewis Bossing, a senior staff attorney at the Bazelon Center for Mental Health Law, a Washington, D.C.-based advocacy organization for people with mental illness, said the "ground-breaking" settlement capped a flurry of federal legal activity in disability cases during the past 18 months. Bossing said the Justice Department, by spelling out an array of community services required to meet Olmstead criteria "will make it more likely that states will change the way they do business with people with disabilities."

Over the past year and a half, Department of Justice attorneys:

-- Filed a brief in support of North Carolina litigation seeking to keep two individuals with developmental disabilities in community settings. A proposed cutoff of funds jeopardized the housing for the two. Perez said in an April statement about the case, "We will not allow people with disabilities to be a casualty of the difficult economy."

-- Filed a motion to intervene in a lawsuit in New York seeking supported housing units for thousands of residents of "adult homes."

-- Filed briefs in existing lawsuits in Florida, Illinois and New Jersey against what the agency called "unnecessary institutionalization" of people with disabilities.

The Justice Department began probing the Georgia mental hospitals in 2007 after a series in the Atlanta Journal-Constitution found dozens of patients died under suspicious circumstances in the state-run facilities. The newspaper also chronicled abuse by hospital workers; overuse of medications to sedate patients; and discharge of many patients to homeless shelters.

The state agreed to improve the hospitals in a January 2009 agreement with the Justice Department, in the final days of the Bush administration. But a coalition of consumer groups filed a brief in opposition to that settlement, saying it failed to improve hospital discharge planning and services in the community.

The Justice Department later backed away from the original terms of the deal and eventually added the Olmstead issues in a separate complaint in January. Last month, the federal judge in the case ratified the original hospital agreement, but let the Olmstead portion proceed, which culminated in the second agreement. The community services pact will have an independent monitor to assess its progress.

Change can't happen soon enough for Rhonda Davidson. She was discharged from a Milledgeville, Ga., mental hospital when the state closed her unit earlier this year. While Davidson, who has schizophrenia, has found a group home in metro Atlanta to live in, she has not received the treatment program and employment help she needs, says her attorney, Sue Jamieson of the Atlanta Legal Aid Society. This agreement should help accelerate that help for Davidson and others, Jamieson said.

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JUSTICE DEPARTMENT OBTAINS COMPREHENSIVE AGREEMENT REGARDING THE STATE OF GEORGIA'S MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SYSTEM

WASHINGTON - The Justice Department today announced that it has entered into a comprehensive settlement agreement that will transform the state of Georgia's mental health and developmental disability system and resolve a lawsuit the United States brought against the state. The lawsuit alleged unlawful segregation of individuals with mental illness and developmental disabilities in the state's psychiatric hospitals in violation of the Americans with Disabilities Act (ADA) and the Supreme Court's landmark decision in *Olmstead v. L.C.*

The U.S. District Court for the Northern District of Georgia will retain jurisdiction to enforce today's settlement agreement, which supersedes a 2008 agreement between the state and the Office for Civil Rights of the U.S. Department of Health and Human Services (HHS) concerning Georgia's provision of community services for individuals with mental illness and developmental disabilities. In light of today's agreement and the progress the state has made in complying with an earlier agreement regarding the conditions in the psychiatric hospitals, the United States has agreed to withdraw its motions to enforce that earlier agreement.

More than a decade ago, in *Olmstead v. L.C.,* the Supreme Court found that one of Georgia's state hospitals was impermissibly segregating two individuals with disabilities in that hospital when they could have been served in more integrated settings. The Supreme Court ordered states to serve individuals with disabilities in the most integrated settings appropriate to their needs.

"The *Olmstead* decision strongly affirmed that people with disabilities have a right to live and receive services in the most integrated setting appropriate for them as individuals," said Thomas E. Perez, Assistant Attorney General for Civil Rights. "Under this agreement, the state of Georgia will provide services in the community to hundreds of people with developmental disabilities and thousands of people with mental illness. The promises of the ADA and *Olmstead* will finally become a reality for individuals in Georgia with mental illness and developmental disabilities."

"Georgia is the home of the Supreme Court's *Olmstead* decision," said Sally Quillian Yates, U.S. Attorney for the Northern District of Georgia. "With this agreement, the state begins to make good on *Olmstead*'s promise to end the inappropriate segregation of people with disabilities in state hospitals that set apart from the community."

"The expansion of community living opportunities is critical to protecting the civil rights of individuals with disabilities under *Olmstead*, said Georgina Verdugo, Director of the Office for Civil Rights at HHS. "The specific requirements and timelines in this agreement will ensure that Georgians with mental illness and developmental disabilities have the services they need to live full lives in the community and achieve their goals."

The Justice Department began its investigation in 2007, and found that preventable deaths, suicides and assaults occurred with alarming frequency in the state hospitals. In January 2009, the department entered into a settlement agreement with the state of Georgia regarding conditions in the hospitals. Further investigation found that the state also failed to serve individuals with mental illness and developmental disabilities in the most integrated setting appropriate to their needs, in violation of the ADA and the *Olmstead* decision. In January 2010, the department filed a freestanding complaint under the ADA and a motion for immediate relief seeking to protect individuals confined in the hospitals from continued segregation and from threats of harm to their lives, health and safety. The department subsequently entered into extensive settlement negotiations with Georgia, the Office for Civil Rights and local mental health advocates.

The agreement signed today resolves the ADA lawsuit. The agreement expands community mental health services so that Georgia can serve individuals with mental illness and developmental disabilities in the most integrated setting appropriate to those individuals' needs. Under today's agreement, over the next five years, Georgia will increase its assertive community treatment, intensive case management, case management, supported housing and supported employment programs to serve 9,000 individuals with mental illness in community settings. The agreement will also increase community crisis services to respond to and serve individuals in a mental health crisis without admission to a state hospital, including crisis services centers, crisis stabilization programs, mobile crisis and crisis apartments; create at least 1,000 Medicaid waivers to transition all individuals with developmental disabilities from the state hospitals to community settings; and increase crisis, respite, family and housing support services to serve individuals with developmental disabilities in community settings.

The Civil Rights Division enforces the ADA which authorizes the attorney general to investigate whether a state is serving individuals in the most integrated settings appropriate to their needs. Please visit www.justice.gov/crt to learn more about the *Olmstead* decision, the ADA and other laws enforced by the Justice Department's Civil Rights Division.

The agreements in this case protecting the rights of individuals with mental illness and developmental disabilities in Georgia are due to the efforts of the following Special Litigation Section attorneys: Judy Preston, Acting Chief; Mary Bohan, Deputy Chief; Timothy Mygatt, Special Counsel; Robert Koch, Max Lapertosa, Richard Farano, Aaron Fleisher, Jeffrey Murray, Jennifer Mondino, David Deutsch, Emily Gunston, Samantha Trepel, and Amin Aminfar, Trial Attorneys. In addition, the division received support and assistance from Aileen Bell-Hughes and Mina Rhee, Assistant U.S. Attorneys for the Northern District of Georgia.

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