MEMO

To: Office of Management & Budget

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

Disabilities Law Program, Community Legal Aid Society, Inc.
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities

Subject: Division of Substance Abuse and Mental Health FY 14 Budget

Date: November 13, 2012

Please consider this memo a summary of the oral presentation of Brian J. Hartman, Esq. on behalf of the Disabilities Law Program ("DLP"), the Developmental Disabilities Council ("DDC"), the Governor's Advisory Council for Exceptional Citizens ("GACEC"), and the State Council for Persons with Disabilities ("SCPD"). We are addressing one (1) component of the DSAMH budget, i.e., the need to fund the community-based mental health system to ensure compliance with the 2011 U.S. Department of Justice Settlement Agreement.

Settlement Agreement Requirements

The State of Delaware recently completed its first year under a Settlement Agreement with the U.S. Department of Justice, implemented to divert individuals from institutional care to community-based treatment options, as required by the Americans with Disabilities Act and the Supreme Court decision in *Olmstead*. The Settlement Agreement sets out specific deadlines by which the State must achieve concrete levels of community-based services for individuals with mental illness.[1] The State successfully met the majority of the FY 2012 benchmarks imposed by the Agreement.[2] The State was praised for this work by Assistant U.S. Attorney General Thomas E. Perez, in his testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions this summer.[3] Delaware's progress in creating a consumer oriented mental health system was also commended in the Court Monitor's September 5, 2012 Second Report to the U.S. District Court for the District of Delaware. The Court

[1] An excerpt from the Settlement Agreement, *Implementation Timeline*, Pgs. 10-14 is included as Attachment "A." The full document is available online at http://dhss.delaware.gov/dhss/admin/files/settlementagreement.pdf.

[2] A copy of the *Second Report of the Court Monitor on Progress Toward Compliance with the Settlement Agreement: U.S. v. State of Delaware*, September 5, 2012, is included as Attachment "B." The report is also available online at http://dhss.delaware.gov/dhss/admin/files/monitorreport_usvde.pdf.

[3] The testimony submitted by Assistant Attorney General Thomas E. Perez to the U.S. Senate Committee on Health, Education, Labor and Pensions, Washington D.C., June 21, 2012, is included as Attachment "C." It is also available online at http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html.

Monitor noted that "the State's reform efforts are translating into real, palpable changes for individuals with [severe and persistent mental illness]."

However, the level of services required by the Agreement increases every year. By the end of FY14, the Agreement requires the following levels of service be implemented:

- Housing vouchers or subsidies and bridge funding to a total of 550 individuals, an increase of 100 new individuals from the end of FY 2013;
- Supported employment to total of 700 individuals, an increase of 300 new individuals from the end of FY 2013;
- Rehabilitation services to a total of 1100 individuals, an increase of 500 individuals from the end of FY 2013;
- Family and peer supports to a total of 750 individuals, an increase of 250 new individuals from the end of FY 2013;
- 9 Assertive Community Treatment ("ACT") teams, an increase of 1 additional ACT team from the end of FY 2013; and
- 18 case managers, an increase of 3 additional case managers from the end of FY 2013.

These performance measures show that in addition to providing services to increasing numbers of individuals each year, the State is also responsible for maintaining services to those individuals already receiving them.

It is especially important to ensure that DSAMH has ongoing funds to provide housing in the community to individuals pursuant to the Settlement Agreement. As noted in the Second Report of the Court Monitor, housing vouchers from the State have already enabled 91 individuals to move into the community, with an additional 60 individuals preparing to transition to the community. Of particular note, the Court Monitor reports that 25.5% of those individuals who have received housing vouchers so far are individuals who were formerly homeless or had experienced four or more episodes of homelessness in the past three years.

Recommendation

We respectfully request funding DSAMH at a level sufficient to ensure Delaware will be able to meet the FY 14 benchmarks pursuant to the Settlement Agreement. Funding community-based mental health supports and services is critical to Delaware's obligations outlined in the Settlement Agreement.

Thank you for your consideration.

Attachments.

G. **Family and Peer Supports**

1. **Family Supports**

a. Family supports are designed to teach families skills and strategies for better supporting their family members' treatment and recovery in the community. Supports include training on identifying a crisis and connecting people in crisis to services, as well as education about mental illness and about available ongoing community-based services.

b. Family supports can be provided in individual and group settings.

2. **Peer Supports**

a. Peer supports are services delivered by trained individuals who have personal experience with mental illness and recovery to help people develop skills in managing and coping with symptoms of illness, self-advocacy, identifying and using natural supports.

b. Peer supports can be provided in individual and group settings, in person or by phone.

H. The State shall ensure that providers of services listed in this Section (II) have linguistic and cultural competence to serve all individuals in the target population.

III. **Implementation Timeline**

A. **Crisis Hotline**

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.

B. **Mobile Crisis Services**

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.

C. 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.

D. 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.

E. Crisis Apartments

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

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.

F. Assertive Community Treatment

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 teams that are 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.

G. Intensive Case Management

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.

H. Case Management

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.

I. Supported Housing

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).

J. Supported Employment

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.

K. 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.

L. 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.

IV. Transition Planning

A. Assessment and Placement of People Currently in Institutional Settings

1. Each individual, now in or being admitted to DPC or an IMD, shall have a transition team including clinical staff and a representative of a community-based mental health provider.

   a. Discharge planning shall begin upon admission.

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

SECOND REPORT OF THE COURT MONITOR ON PROGRESS TOWARD COMPLIANCE WITH THE SETTLEMENT AGREEMENT: U.S. v. STATE OF DELAWARE

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

September 5, 2012

I. Introduction

This is the second report by the Court Monitor ("Monitor") on the implementation of the Settlement Agreement between the U.S. Department of Justice ("DOJ") and the State of Delaware ("the State"), covering the six-month period January 15, 2012 through July 15, 2012. As was discussed in the Monitor's initial report, the State has responded to the requirements of the Settlement Agreement not only with the intent of meeting the numeric targets, but also with the goal of restructuring systems so that the its public programs produce outcomes that are consistent with the Americans with Disabilities Act ("ADA") and the U.S. Supreme Court's *Olmstead* decision. The Settlement Agreement targets a specific population of Delawareans with disabilities, those with Serious and Persistent Mental Illnesses ("SPMI"). As such, the State's Division of Substance Abuse and Mental Health ("DSAMH") within the Department of Health and Social Services ("DHSS") has been at the center of implementation activities. Kevin Ann Huckshorn, in her capacity as Director of DSAMH, has had a primary role in providing assistance and working through issues with the Monitor, and in effecting the innovative reforms in programs and service culture described in this report. At the same time, from Governor Jack Markell through DHSS Cabinet Secretary Rita Landgraf, there has been a clear recognition that the fulfillment of the ADA for citizens with SPMI requires the alignment of programs across state departments and on the county and local levels. Accordingly, the findings presented below include specific instances where the State is working across traditional bureaucratic boundaries to achieve not only the letter, but the spirit of the Settlement Agreement.

Furthermore, leadership within the State has an understanding that the opportunities and the lessons of reform efforts pursuant to the Settlement Agreement have critical meaning for people with SPMI, and for other populations with disabilities, as well. For this reason, in its implementation efforts DHSS is increasingly including representatives of programs working on behalf of individuals with physical or intellectual/developmental disabilities. Such efforts are not at all superfluous to the Settlement Agreement. They clearly support the State in meeting its broader obligations under the ADA, and to the extent that the changes in culture and practice brought about through the Settlement

Agreement are infused in public programs statewide for all individuals with disabilities, the sustainability of the reforms that are discussed in this report is heightened.

As is detailed below, the State is largely meeting its benchmarks and it is making significant, sometimes ground-breaking, progress in retooling its systems in fulfillment of the ADA. This has not been a simple, linear process. The Settlement Agreement required that in this first year, a multitude of new services and procedures be launched simultaneously, inevitably causing some disruptions, uncertainty and unanticipated challenges. In some instances, these concurrent changes affected the State's ability to meet its implementation target dates, for instance, in recruiting mobile crisis staff in an environment of newly heightened competition for mental health professionals (due to other expansions required by the Agreement). In addition, as is referenced repeatedly below, DSAMH is seriously challenged by fragmented, outmoded and ineffective data systems that are critical to its management of services and future planning.

Still, at this juncture, things are finally settling into a new—and better—"normal," whereby longstanding gaps in services (particularly in the southern counties) are being addressed and new initiatives supporting integrated community living are being put in place. Most significantly, the State's reform efforts are translating into real, palpable changes for individuals with SPMI. The Monitor has had an opportunity to meet with several beneficiaries of the Settlement Agreement—all of whom with long histories of institutional segregation, multiple psychiatric crises, homelessness or involvement with criminal justice systems. They are now living in ordinary, scattered-site housing, receiving flexible community-based services and supports. Their days are spent in such mundane activities as shopping, cooking, housekeeping, or working. Given that just a year ago, these individuals would likely be living in hospitals, correctional settings or congregate facilities, this is a remarkable achievement. As contemplated by the Settlement Agreement and, more broadly, the ADA, these individuals are living "like the rest of Delawareans."[1]

II. Sources of Information

The findings presented here are based upon a broad set of information sources. They include regular meetings with the leadership of DHSS, DSAMH, various state agencies and providers; peer advocates; local chapters of organizations such as Mental Health America and NAMI; the Delaware Psychiatric Center ("DPC") and other psychiatric inpatient providers; and individual consumers of public mental health services in the state. In addition, the Monitor has convened or participated in a number of work groups dealing, for instance, with issues such as legislative reform, risk management, discharge planning, housing, and data systems. The Monitor has also reviewed numerous reports,

[1] Settlement Agreement, Section II.E.1.a

policies, minutes, inpatient and outpatient case records, data sets and other material relating to implementation. Without exception, the State has continued to provide the Monitor with requested information, facilitated access to any individual or group with whom the Monitor sought contact, and otherwise offered full and helpful assistance in carrying out the monitoring functions delineated in the Settlement Agreement.

III. Infrastructure and System Configuration

The Monitor's January 30, 2012 report on implementation during the initial six months referenced two areas not specifically delineated within the Settlement Agreement as requirements, but nonetheless critical to meaningful implementation:

- Stakeholders' understanding of measures required by the Settlement Agreement and of the ADA and the *Olmstead* decision which underlie these requirements; and
- Reconfiguration of public systems to comport with the Settlement Agreement, including centralized oversight to ensure that services are least restrictive, most integrating, and meeting the needs of people with SPMI who are served in public programs.

The State has made significant progress in each area.

A. Stakeholders' Understanding of the Settlement Agreement

In the initial report, the Monitor found that, notwithstanding the fact that the ADA was enacted over twenty years ago, a meaningful understanding of this pivotal legislation and its implications for practice tended to be limited to managerial staff system-wide. On a direct service level, staff knowledge about the ADA was often superficial, with little evident impact on their interventions with individuals. As a consequence, longstanding practices that are at odds with the ADA and *Olmstead* continued without question. Further, people being served by DSAMH's programs often had at best a vague understanding of their own civil rights. Accordingly, the Monitor recommended training on the ADA, the *Olmstead* decision and the Settlement Agreement with the goal of increasing stakeholders' understanding of the underlying principles and their practical meaning.

In the ensuing months, DSAMH has provided relevant training—sometimes involving the Monitor—within DPC (e.g, with Recovery Academy staff, social work staff and medical staff) and externally (e.g., with professional organizations such as the Delaware Organization of Nurse Leaders, police chiefs, judges, the Sussex Mental Health Task Force, the Sussex Interagency Council, and the Delaware Rural Health Initiative). These

trainings continue on an ongoing basis. A number of town hall meetings have been held across the state, including representatives from DHSS, NAMI, the Mental Health Association in Delaware ("MHA"), the Delaware protection and advocacy agency, leaders in consumer-run coalitions, consumers, families and other concerned citizens.

Furthering these formal training efforts, the local news media has been actively covering the Settlement Agreement's implementation and related reform efforts (such as the new mental health legislation discussed below), thus increasing awareness of the ADA and its meaning among the general public. Notably, the Summer, 2012 newsletter of MHA included an extensive interview with the Monitor relating to the ADA and the Settlement Agreement; this publication was promulgated as an insert with the state's major local newspaper, thus getting very wide circulation.

B. System Reconfiguration

The Monitor's initial six-month report cited two structural aspects of Delaware's public mental health system that were in conflict with the requirements of the Settlement Agreement in that they have promoted unnecessary institutional segregation, confounded appropriate oversight, and complicated effective community services. These were the poorly controlled use of civil commitment and DHSS's oversight of psychiatric inpatient care.

A. Civil Commitment

The Monitor's last report referenced various gaps in legal protections against the unwarranted detainment, hospital confinement and continuing court oversight of individuals with SPMI. As a consequence, individuals on the Targeted Population List were at unnecessary risk of involuntary hospitalization and the attendant trauma, as well as questionable legal coercion via outpatient commitment orders. As a case in point, the Monitor's report presented the story of Mrs. L, an individual with SPMI who was actively engaged in community-based treatment. Although not dangerous to herself or others, Mrs. L came to be transported in handcuffs by police from an emergency room (where she had come on her own with delusional physical complaints) to a psychiatric hospital. Notwithstanding the fact that she was not a danger, she was subsequently civilly committed on the basis of dangerousness. The outpatient team that had been providing Mrs. L with comprehensive community based services was not consulted about these actions. There is good news relating to Mrs. L. She is no longer subjected to court-ordered treatment and, in fact, as a beneficiary of the Settlement Agreement, she is now successfully living in her own apartment with continuing community supports.

There is also good news to report on a systemic level. The Delaware legislature recently enacted House Bill 311 and House Joint Resolution 17, both signed into law by Governor

Markell on July 24, 2012. House Bill 311 rectifies an issue that directly affected Mrs. L; it requires an assessment by a qualified mental health screener before an individual is detained on a 24-hour psychiatric hold, thereby helping to ensure that detainment and hospitalization only occur when it is clinically necessary and that the individual is afforded appropriate access to the less-restrictive alternatives being developed across the state. This legislation also updates the mental health law that had been in effect in Delaware for many decades, incorporating language about community integration, requiring that care be provided on a voluntary basis whenever it is feasible, and removing an unintended incentive for civil commitment whereby in certain circumstances, the State would only underwrite involuntary hospital care.

Having thus remedied some immediate critical problems, the companion legislation, House Joint Resolution 17, creates a study group to evaluate the State's mental health law in its entirety and to make recommendations for further reforms. Governor Markell, Cabinet Secretary Landgraf, members of the legislature—in particular, Representative Barbieri—merit great credit for engaging a broad array of stakeholders with very diverse perspectives and quickly moving these important bills to enactment. As the provisions of House Bill 311 become effective, significant "front door" issues that have culminated in unwarranted hospitalization and legal coercion should be rectified. Furthermore, the statewide processes for responding to psychiatric emergencies should become much more aligned with the State's obligations under the Settlement Agreement. The study group that will be formed under House Joint Resolution 17 will have an opportunity to further these gains.

The Monitor's initial report also referenced the frequent use of continuing outpatient commitment orders following involuntary hospital care. In conflict with *Olmstead,* these outpatient commitment orders place significant numbers of individuals within the Target Population under questionable legal coercion and at heightened risk of unwarranted rehospitalization. Based upon a review of records and discussion with informants (both within the initial six-months and more recently), the Monitor has found that these orders for continuing court supervision are issued routinely, sometimes in the absence of an explicit clinical rationale and, commonly, without a record of why this is the least restrictive measure appropriate to the individual's circumstances. Furthermore, these court orders can be remarkably vague, not only failing to specify the community provider that is responsible for delivering the court-ordered services, but also failing to specify what these services are. Notwithstanding such ambiguity, these court orders indicate that individuals who are outpatient committed can be re-hospitalized if they are not "amenable" to such treatment.

Delaware remains very much an outlier in its use of outpatient commitment, not only in comparison with neighboring states (where such orders are rarely, if ever, used) but also in comparison to New York, where outpatient commitment is used and well studied. As

at least a blunt measure of the overuse of court-ordered services in Delaware, following recent discussions with the Monitor, one major community provider determined that it was appropriate to terminate court supervision of about 40% of its clients who had active outpatient commitment orders.

Recommendations:

1. Although recent legislative reforms will not come to be fully in effect for another year, pursuant to the Settlement Agreement the State launched a number of service improvements which should have a more immediate impact in reducing questionable hospital admissions and the attendant involvement of the judicial system. As a means of evaluating and improving the impact of these reforms, the Monitor recommends that the State track changes in the following measures:

    a. Involuntary Hospitalizations

    b. Voluntary Hospitalizations

    c. Outpatient Commitment Orders

    The Monitor recommends that these measures be evaluated not only with respect to the State's own baselines (perhaps using data from the past year or two) but also, to the extent that information is available, population-adjusted data from neighboring states. Such information is not only useful for Performance Improvement purposes, but can also provide stakeholders with an indication of the State's progress towards a more *Olmstead*-oriented service model.

    Although these measures are fairly basic, the State's ability to collect and analyze such data is currently challenged by its inadequate electronic information systems. A fuller explanation of this problem and the need for immediate remedies is presented in a later portion of this report.

2. The State has begun to examine how, within the legislative and policy structures now in effect, it can improve documentation that is presented to Mental Health Commissioners (who issue orders for involuntary psychiatric treatment) so that the basis for court-ordered treatment—whether inpatient or outpatient—is more specific and includes clear information as to why less-restrictive measures are not seen as viable. The Monitor recommends that the State quickly move forward in this initiative, certainly because of its obvious legal implications, but also because requiring more explicit documentation can have the effect of reinforcing *Olmstead*-oriented decision making among the parties involved.[2] Furthermore, piloting

[2] The Monitor notes that changes in documentation requirements are having a similar effect in reorienting the system towards housing and service models that promote integration see discussion relating to Section IV.B.1.

improved documentation may inform the work of the study group's review of Delaware's mental health laws, pursuant to House Joint Resolution 17.

3. In examining the Delaware's decades-old mental health laws, the study group that was created through House Joint Resolution 17 will have the opportunity to make recommendations that build on House Bill 311 in further embedding the values and requirements of the ADA in practices within the State. The Monitor recommends that the diverse stakeholders the study group comprises give careful consideration to how further revisions in Delaware's law can solidify the gains that are now being made pursuant to the Settlement Agreement.

2. Oversight of Psychiatric Hospitalizations:

The Monitor's initial report noted that the State's overly-complex arrangements for managing services to people with SPMI posed significant problems in assuring that appropriate interventions are provided, that rights are protected, and that public resources are utilized efficiently. Part of the problem is that there has not been a single point of accountability for public services to people with SPMI; instead, oversight is within DSAMH, within the State's Medicaid program, within both, or shifting between the two entities. The consequences of this arrangement have been evident in a number of ways, including questionable use of hospital emergency departments and inpatient psychiatric beds, poor coordination of outpatient and inpatient services, and inpatient psychiatric admissions of individuals whose fundamental problems are substance abuse. The Monitor found that these problems in managing services not only compromised the rights of individuals on the Target Population List, but also had the effect of drawing on public resources for high-end services (such as hospital care) that are either preventable or unneeded. To a significant degree, the processes that sustain these inefficiencies appear to represent an accumulation of decades of policies and practices, rather than an overall plan to provide effective mental health services in accordance with the ADA and related laws.

During the past six months, the Monitor has regularly met with leadership in DHSS and DSAMH to discuss ways of enhancing the management of services and service-dollars. Several of the Monitor's recommendations from the initial report have been addressed, for instance, House Bill 311 addresses financial incentives favoring involuntary treatment.

In addition, the State has expanded its staffing of the Eligibility and Enrollment Unit ("EEU") by six staff members. Many of these positions have been filled and recruitment efforts are underway to bring the EEU to full staffing. The expansion in the EEU will allow this unit to apply eligibility and placement criteria to a broader range of services and to begin to perform Utilization Reviews in different service settings. Included will

be services to the over 1,300 individuals who were successfully transitioned from existing community programs into the new Assertive Community Treatment ("ACT") and Intensive Case Management ("ICM") programs that have been developed pursuant to the Settlement Agreement (they are discussed elsewhere in this report). Finally, with passage of House Bill 311, the EEU will have responsibility for tracking and managing all inpatient psychiatric care and community services for publicly-funded individuals with SPMI.

Two issues of great importance to meaningful compliance with the Settlement Agreement are currently under discussion with DHSS and DSAMH:

- The most appropriate format for DSAMH's system-wide Quality Assurance ("QA") and Performance Improvement ("PI") programs. QA and PI are related functions, but with distinct methods and goals; simply stated, QA looks back at services rendered and works to ensure conformity with standards, while PI draws on QA data and other sources with the aim of enhancing outcomes and efficiency. These functions are currently consolidated in a single DSAMH program. Given the new program expansions, changes in service structure, needs for refinement of policies and procedures, and demands for future planning, DSAMH is examining how to most effectively carry out these functions.
- Establishing a coordinated process for care management. Presently, responsibility for the oversight of services and reimbursement to individuals with SPMI is dispersed among DSAMH, Medicaid and Medicaid Managed Care Organizations. This not only presents problems in monitoring the flow of services and related expenditures, but also in assuring that all individuals on the Target Population List are appropriately afforded access to the array of services that are developed per the Settlement Agreement.

As discussions proceed and planning around these issues is solidified, the State will need to address an issue that is frequently referenced in this report: the data systems that are critical to effectively carrying out QA/PI and care management are not in place, and there are apparently bureaucratic hurdles to be overcome if appropriate IT systems are to be established.

Recommendations Carried Forward from the Initial Report:

1. In collaboration with the Monitor, the State should begin analyses of inappropriate admissions to DPC and the private psychiatric hospitals ("IMDs"). To further the expanded oversight by the EEU and to provide a basis for root-cause analyses, DSAMH should instruct DPC and IMDs to flag admissions of publicly-funded individuals where the need for inpatient psychiatric care is questionable.

2. In collaboration with the Monitor, the State should initiate a study of hospital emergency departments and how they deal with individuals who have substance abuse disorders and who do not have justifiable co-existing diagnoses of SPMI. The focus should be on developing a system of care that appropriately addresses their needs and that rectifies the current misuse of public psychiatric beds.

New Recommendations:

1. In the coming months, the Monitor plans to engage an expert consultant to evaluate the needs of DSAMH with respect to system-wide Performance Improvement and to make recommendations relating to the scope, key tasks and infrastructure needs.

IV. Progress On Specific Provisions

A. Explanation of Ratings

In this section, the Monitor presents brief summaries of the State's progress in fulfilling specific provisions of the Settlement Agreement, particularly those with defined target dates. In accordance with the Settlement Agreement, for each goal the Monitor has made a determination as to whether the State is in "Substantial Compliance," "Partial Compliance," or "Noncompliance" (Section VI.B.3.g defines these ratings). Many of the provisions relate to what will be ongoing processes or interim steps toward long-range goals over the five years of implementation. The ratings presented below represent the State's levels of compliance with each provision during the period July 15, 2011 through July 15, 2012.

B. Evaluations of Compliance

II.B.1-2 The Settlement Agreement requires the development of a "Target Population List," as follows:

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;

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

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

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

Partial Compliance.

The Monitor's prior report referenced that, the importance of the Target Population List notwithstanding, constructing and maintaining this list has been a daunting task. As in other states, Delaware's public systems do not have data systems that were designed to communicate with each other. Many rely on outdated software and inefficient modes of data submission. This is the case not only across state departments, but also within DHSS and its various bureaucratic sections.

As was verified by an expert consultant hired by the Monitor to assist the State, DSAMH is using information technology that is not only insufficient to address the basic requirements of constructing a Target Population List, but it also lacks a capacity to access timely and accurate data that are essential to the overall monitoring and management of services that are referenced throughout the Settlement Agreement. Among other findings, the consultant noted that DSAMH collects important data that it cannot easily or meaningfully extract for routine oversight or long range planning. Data submission relating to services provided through its programs is a hodgepodge of electronic and paper transmissions, none of it in real time and much of it requiring manual entry and tedious error correction. Lacking an overall unified system, key information (for instance with regard to the disposition of hospital discharges and housing created pursuant to the Settlement Agreement) is maintained in spreadsheets

improvised by various staff members. DPC does not yet have a system for electronic medical records and DSAMH confronts bureaucratic barriers to introduce much needed improvements.

Based on the report of the Monitor's expert consultant, DSAMH will need help to expedite the procurement and implementation of an electronic health record and redesign of a database that can more appropriately provide data on individuals affected by the Settlement Agreement. The Monitor has learned that the State's restrictive IT security standards complicate the procurement of software products (among them, Electronic Health Records) that can vastly improve the efficiencies of service delivery and oversight.

That said, and acknowledging the significant effort required of DSAMH's IT staff, the State's Target Population List includes 6,373 unduplicated names as of May 31, 2012. The list includes individuals with SPMI who are receiving state-funded inpatient psychiatric care or who were admitted to such care during the two-year period prior to the date the Settlement Agreement took effect (representing about 3,000 admissions). For this same period, it includes 990 individuals with SPMI who have been homeless. Drawing from Medicaid claims data, it also includes information about 1,638 individuals who were admitted to emergency departments of general hospitals, apparently for treatment of issues attendant to SPMI (this required some inference based on diagnostic information, since there is apparently no distinct coding that would flag psychiatric emergency care in these settings). Although individuals who have received treatment at DPC under forensic orders are included on the Target Population List, DSAMH has not yet established mechanisms to access data relating to criminal justice involvement by individuals with SPMI. This is a significant gap in the database. And again, the status of DSAMH's IT systems is such that generating the critically important information to maintain and utilize the Target Population List is a labor-intensive enterprise, using information that is not consistently current.

Recommendations:

Because issues relating to information technology are central to this provision of the Settlement Agreement and are also intertwined with other provisions, the following recommendations have bearing on the State's fulfillment of other sections, as well. DHSS is aware that its IT systems are antiquated and siloed. A Department-wide overhaul of IT systems is already underway, with the goals of vastly improving access to information needed for oversight and decision making, and integrating information across DHSS's various Divisions. Because of the complexity of this process, the planned creation of a State Data Hub and other IT elements needed to fully achieve the Department's goals will not be immediate. At the same time, fulfillment of the

Settlement Agreement requires that some data issues be immediately addressed, likely through temporary measures as the State's longer-range IT improvements proceed.

1. DHSS should quickly move forward in resolving restrictions to accessing data from other state agencies, particularly the State's Department of Justice and Department of Corrections. Not only is this essential to fully meeting requirements relating to the Target Population List, but real-time criminal justice data about individuals on that list can enable mental health providers to intervene to prevent arrests and further involvement with the legal system. The Monitor is aware of electronic systems that are able to carry out this function while protecting the confidentiality of individuals receiving mental health services.

2. DHSS should consider the recommendations of the consultant engaged by the Monitor as it continues to refine plans for an upgrade of IT systems within DSAMH and other related Divisions.

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

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

Substantial Compliance.

The Crisis Hotline is in place and is operational around the clock, as evidenced by random quality checks. DSAMH has promulgated information about the Crisis Hotline by distributing postcards through its peer-specialist and provider networks, and through advertising panels at major shopping malls in the state.

III.B.1 *Mobile Crisis Services: 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.*

Partial Compliance.

During the initial four months of this calendar year, mobile crisis teams responded to a monthly average of 40.5 emergencies statewide, 70% of which occurred in New Castle County with the remainder roughly equally divided between the two southern counties. The State has not been tracking the specific time it takes for mobile crisis staff to

physically arrive to intervene in emergencies, but it reports that staff members are deployed on average within 13 minutes of the a request for assistance and they return to base on average within about two hours. Assuming that a face-to-face intervention lasts around one hour, and considering the State's small geographic size, it is possible that the state is meeting the one-hour requirement specified in the Settlement Agreement. Looking forward, the State should directly measure compliance with this provision.

The Monitor notes that there are as many as seven vacancies for related positions within the Kent and Sussex Counties, in large part as a result of the competition for qualified mental health staff associated with the new programming that is being developed there under the Settlement Agreement and the reality that such positions are hard to fill due to the level of education and experience required. It is unclear how these vacancies are affecting the mobile crisis response in those counties, where requests now average only slightly more than one per week, and how demand may change as the Ellendale facility (discussed immediately below) reaches its full impact in the region.

Recommendations:

1. As referenced in the above section, the State needs to improve its capacity for data collection and management, including its ability to capture data reflecting the time between receipt of a request for crisis intervention and the arrival of staff on the scene.
2. In order to ensure that resources are appropriately in place statewide, data relating to response times should be tracked on a county-by-county basis, including day, time of day, and specific responders.

III.C.1 *Crisis Walk-in Centers: 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.*

Substantial Compliance.

Renovations to the Ellendale Crisis and Psychiatric Assessment Center ("CAPAC") were completed on June 25, 2012. The State contract for the program was awarded to Recovery Innovations and, as of the time of this report, that new provider is training staff. In keeping with the timeline in the Settlement Agreement, CAPAC will be fully operational by September 1, 2012. The Ellendale site is now providing at least limited crisis services on a 24-hour basis, 7 days per week to Delaware's southern counties, in partnership with the State's Mobile Crisis Intervention Team.

III.D.1 *Crisis Stabilization Services 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.*

Substantial Compliance.

Currently, crisis stabilization services occur within Crisis and Psychiatric Emergency Services ("CAPES"), the psychiatric crisis center serving northern Delaware that is located within Wilmington Hospital-Christiana Care. As is discussed above, in September, 2012, a crisis center serving the lower counties will open in Ellendale. CAPES presently has a bed capacity of 5 beds, and CAPAC will have 6 beds. Approximately 75% of individuals who are admitted to CAPES stay less than eight hours. When individuals are being served by community programs, staff at CAPES consults with the providers as a part of the assessment process and the determination of an appropriate disposition. Based on the Monitor's review, individuals are receiving appropriate transition planning. The Monitor will review practices at CAPAC when that facility is operational.

III.E.1 *Crisis Apartments: By July 1, 2012 the State will make operational two crisis apartments.*

Substantial Compliance.

As of this report, community providers statewide have a capacity to access up to six crisis apartments and to provide associated short-term services, thereby exceeding the capacity required by the Settlement Agreement. As new services come to be fully operational (for instance, statewide mobile crisis) and new and existing providers assume roles in the reorganized system, the Monitor will evaluate how these crisis beds are being used.

III.F.1 *Assertive Community Treatment: By July 1, 2012 the State will expand its 8 ACT teams to bring them into fidelity with the Dartmouth model.*

Substantial Compliance.

The State is exceeding the requirements of this provision, having awarded contracts for ten ACT teams statewide, all under contract and fully operational as of this report. The parties to the Settlement have agreed that in place of the Dartmouth operational

standards, these teams will demonstrate program fidelity through the Tool for Measurement of Assertive Community Treatment ("TMACT"), a newer assessment instrument with enhanced requirements for person-centered services and recovery planning. During the coming year, the Monitor will evaluate the performance of the new ACT teams, some of which represent new providers in the state.

III.G.1 *Intensive Case Management: By July 1, 2012 the State will develop and begin to utilize 3 ICM teams.*

Substantial Compliance.

The State has surpassed this target. As of mid-May, contracts for five Intensive Case Management teams had been awarded. As of this report, these teams are fully functional in New Castle County and have begun operations in Kent and Sussex Counties. During the coming year, the Monitor will be evaluating their performance.

III.H.1 *Case Management: By July 1, 2012 the State will train and begin to utilize 15 case managers.*

Partial Compliance.

In late 2011, the State issued a Request for Proposals ("RFP") for Targeted Care Management ("TCM") in fulfillment of this provision, but received only one response. In March, it reissued an RFP with revised specifications, and a contract with a provider is currently being finalized to provide for 11 case managers with caseloads to be at a level of 1:25. These caseloads are much lower than had been anticipated, but they reflect DSAMH's assessment of the complex needs of the individuals being served. As a result of contracting issue, there has been an understandable delay in fully implementing TCM statewide—not attributable to the State's lack of effort—until the beginning of September, 2012. At the same time, 4.5 TCMs are active on the acute care units of DPC, serving as liaisons to the community for approximately 90 individuals at any point in time. In addition to these 15.5 TCM positions, DSAMH's contracts with ACT providers include a requirement for peer specialists (one per team), whose work complements that of the case managers.

III.I.1 *Supported Housing: 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*

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

Substantial Compliance.

As was reported in the prior report, the State has identified 150 individuals who live in semi-integrated housing and it continues to provide supports allowing these individuals to live successfully in these settings. In some instances, individuals in this group have been able to move to more integrated supported housing.

The Settlement Agreement requires that as of July 1, 2012, the State fund integrated housing for an additional 100 individuals. As of this report, the State has exceeded this goal. Funding for an additional 151vouchers has been approved for individuals on the Target Population List through a combination of programs through HUD, DSAMH, and the Delaware State Rental Assistance Program ("SRAP"). These vouchers have enabled 91 individuals to move into integrated housing, and the additional 60 individuals are in various stages of transition. The Targeted Population List provides some information as to which priority subpopulations (defined above in relation to Section II.B.2) have benefited from these housing expansions (Individuals may be reflected in more than one category):[3]

DPC.....21.9%

IMD.....23.8%

Emergency Department Treatment.....19.2%

Homeless.....25.2%

Inpatient History + Inappropriately Housed per Community Program 33.8%

The Monitor's visits to several such individuals in New Castle County have affirmed that housing and related supports are, indeed, consistent with the requirements of the Settlement Agreement. Individuals with SPMI who would otherwise be living in institutions or congregate settings that segregate them from the community mainstream are now living in nice, scattered-site apartments in ordinary apartment complexes with the flexible array of community supports that is helping them meet their personal goals. It is evident that these individuals (and the providers who assist them) rightly feel a sense of pride in making the goals of the ADA something beyond mere aspirations and demonstrating the true capacities of these Delawareans. During the coming year, the Monitor will continue to assess the State's progress with respect to this pivotally

[3] As discussed elsewhere, criminal justice information is not yet incorporated in the Target Population List

important provision, particularly in the southern counties where housing and supports have historically been a special challenge.

Comment:
It is noteworthy that the DHSS and DSAMH have not only been working to fulfill the quantitative requirements of the Settlement Agreement relating to integrated housing, but they have also taken a leadership role in ensuring that relevant policies and practices are aligned across State departments. For example, Cabinet Secretary Landgraf and Delaware State Housing Authority ("DSHA") Director Anas Ben Addi successfully negotiated changes in the SRAP program to remove barriers that particularly disadvantaged individuals on the Target Population List in qualifying for housing vouchers.

Furthermore, Secretary Landgraf and Director Huckshorn have been instrumental in launching an initiative to examine existing congregate housing in order to identify opportunities to "retool" this housing stock to comport with the ADA's integration requirements. The development of much of this housing either pre-dated the ADA or was based on funding programs that were not structured around the ADA. Because federal disability protections apply to a larger population of Delawareans than is the focus of the Settlement Agreement, the State has broadened discussions about housing reconfiguration to include individuals with developmental, intellectual and physical disabilities, as well as stakeholders concerned with older adults and homeless individuals. DHSS has engaged leadership from DSHA and the federal Department of Housing and Urban Development in this initiative. The goal is to develop an ADA-consistent master plan for integrated housing that spells out actions that can be taken long-range and in the more immediate term to expand opportunities for ordinary mainstream housing.

These two initiatives have great significance. The changes in SRAP policy reflect the goals of the Governor, the Cabinet Secretary and other leadership in the State to not only fulfill the State's specific obligations under the Settlement Agreement, but to also ensure that public programs in Delaware comply with the ADA's wider requirements. The development of an *Olmstead*-oriented master plan for housing individuals with disabilities speaks to the enduring commitment of the State to promote meaningful integration of its citizens with disabilities well beyond the expected five-year period of implementing this Settlement Agreement. Leadership within Delaware should be commended for these measures.

III.J.1 *By July 1, 2012 the State will provide supported employment to 100 individuals per year.*

Substantial Compliance.

The State is surpassing this requirement. Because DSAMH's contracts with Community Continuum of Care Programs ("CCCPs"), included supported employment as a part of the service package, a majority of the 1,300 individuals they served received these services. Pursuant to the Settlement Agreement, these programs reformulated as ACT teams, with supported employment services remaining a contractual element. The Delaware Department of Labor, Division of Vocational Rehabilitation has contracted with each of the ACT teams to strengthen the supported employment services provided. It is noted that supported employment is included among the services offered to the 151 individuals for whom new integrated housing was funded (see discussion of Section III.I.1-2).

The success of these programs is evidenced in the number of individuals currently in competitive employment. As of July 1, 2012, 49 individuals on the Target Population List have been in supported employment for 90 days, and an additional 79 individuals have been in supported employment for at least 10 days. Although on their face, these numbers may appear small, unemployment among people with SPMI is astronomically high nationwide and the State is building on an admirable record of making vocational services and employment opportunities available to this population. There is an expectation that DSAMH's data collection regarding supported employment will improve in the coming year as a function of the reporting requirements of the new ACT and Community Re-Integration Project ("CRISP;" discussed in Section IV.A) programs. The Monitor plans to conduct interviews with a sample of individuals in supported employment during the coming months.

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

Substantial Compliance.

As is the case with regard to supported employment, DSAMH's core database relating to rehabilitation services is derived from reports of providers working under the old CCCP contracts. These generic reports show that 1,395 individuals with SPMI received some level of community-based rehabilitation services. Unlike supported employment, where the impact of services can be measured at least bluntly in the number individuals in gainful employment, the existing data capacities with respect to rehabilitation services are

very limited. Information regarding the provision of rehabilitation services and service outcomes should improve through reporting by the new ACT teams (which replaced the CCCPs) and CRISP, particularly if the State makes the much needed improvements in its IT systems that are referenced throughout this report. Although information about the provision of rehabilitation services over the past year is general, the State has met is numeric targets. The Monitor plans to conduct more targeted assessments of this service requirement during the coming months.

III.L.1 *By July 1, 2012 the State will provide family or peer supports to 250 individuals per year.*

Substantial Compliance.

The State is exceeding its targets with respect to family and peer supports. Between the July 1, 2011 and the date of this report, a total in excess of 416 individuals have received or are receiving such services. These include: 30 inpatients at DPC and served by the hospital's peer program; 49 individuals receiving the services of Bridge Peers, who assist in transition to community living; 250 peers served at the peer-operated Rick VanStory Center in Wilmington; 57 peers served at the Open Door Peer Support Center in Wilmington; 30 individuals receiving supports through the Sussex Drop-in Centers; and an additional number of individuals (unavailable as of this report) who receive supports through the drop-in center located in Dover.

During the past six months, the Monitor has had an opportunity to visit the Rick VanStory Center and to meet with its director, to hear first-hand from individuals now living in integrated housing about the benefits of Bridge Peers, and to meet fairly regularly with the Peer Specialists at DPC. The State has made considerable strides in expanding the role of peers in these settings, as well as in its new ACT teams.

The Peer Specialists at DPC have been active advocates, not only in individualized work with people who are hospitalized, but also in identifying systemic issues, such as those relating to questionably restrictive practices and poor coordination in implementing arrangements for discharge. Under the leadership of Gayle Bluebird, the DPC Peer Services Director (who is nationally known for her work), they also are doing impressive work in the area of trauma, producing a plain-language booklet illustrated with works by peer artists, entitled "What You Need to Know About Trauma."

IV.A *Assessment and Placement of People Currently in Institutional Settings*

Not Rated. (Ratings of provisions in Section IV with specific implementation milestones appear below.)

This section of the Settlement Agreement lays out processes for evaluating the capabilities and needs of individuals who are institutionalized, with the goal of moving people who do not require an institutional level of care into community settings that maximize integration. During the initial six months of implementation, DSAMH's "Barrier Busters" committees—comprising DPC staff, community providers and peers—focused on individuals who are on the hospital's long-term care units. Typically, these individuals have very longstanding problems attendant to SPMI, often with co-occurring physical health issues, substance abuse and legal challenges. Consistent with the Settlement Agreement, Barrier Busters was highly successful in not only problem-solving, but also reorienting transition planning for this population towards a strength-based model of community integration. The Barrier Busters committees (one for New Castle and one for the two southern counties) strengthened the collaboration between hospital staff, community providers and peer specialists and laid the groundwork for the mindset that is now gaining traction system-wide, whereby an individual is presumed appropriate for integrated supported housing unless otherwise demonstrated.

Understanding the sometimes unique needs of the long-term care population that was the focus of Barrier Busters—reflecting not only clinical complexities, but also dependencies that are encouraged by protracted institutionalization—the State developed a new program model for the community integration of these individuals, issuing contracts to two providers. The Community Re-Integration Project ("CRISP") is a capitated, shared-risk initiative which allows these community providers great flexibility in delivering traditional and innovative services and supports in integrated settings. Part of the CRISP contracts, which were modeled after another state's successful initiative, hold the involved providers financially responsible for any post-discharge visits to emergency rooms or admission to inpatient psychiatric care. CRISP will become fully operational during the coming months, with each program serving 50 individuals. It is anticipated that the program will result in at least 50 additional discharges from DPC's long term care units. CRISP will also support other individuals with SPMI who may be in the community, but who are high risk for hospitalization at DPC because they have had difficulties engaging in recovery services. As is discussed below, the introduction of CRISP, as well as new processes attendant to transition planning has resulted in DSAMH restructuring how if carries out the centralized special transition functions that had been the focus of Barrier Busters.

IV.B.1 *Implementation of Transition Assessments and Placement: Within 30 days of the signing of the agreement the State will re-assess all individuals currently in institutional settings.*

Substantial Compliance.

The provisions of the Settlement Agreement relating to transition planning are particularly significant to the State's efforts to reorient its systems in support of the community integration required by the ADA. In Delaware (and elsewhere), longstanding practices relating to service planning were built around a "levels of care" framework whereby an individual with SPMI would be matched to the setting regarded as most consistent with his or her needs—for instance, group homes, nursing homes, or supervised apartments. At least in theory, the individual would move through the established levels of care as needs changed. The Settlement Agreement reflects the recognition that this outdated service model tends to perpetuate institutional segregation, in part because service planning is constructed around settings that were state-of-the-art well before the ADA was enacted and when the principal goal was downsizing massive state hospitals.

Consistent with the ADA's goal of ending segregation based on disability, the Settlement Agreement specifies a very different model, requiring that "…assessment shall begin with the presumption that with sufficient supports and services, individuals can live in an integrated community setting."[4] The Settlement Agreement clearly describes an integrated setting as one where "…people with SPMI can live like the rest of Delawareans, in their own homes, including leased apartments, homes or living with family"[5] and includes specific parameters to prevent the new development of settings where people with SPMI are intentionally clustered with other individuals who have disabilities. These requirements are a departure from many of the housing, service and assessment models that have been utilized in Delaware and nationwide over the past decades.

Pursuant to the Settlement Agreement, the State has developed an innovative protocol for assessing individuals based first on a presumption of integrated living and, when this is not feasible (e.g., in light of the intensity of an individual's needs) or consistent with the individual's informed choice, for analyzing and reviewing alternative plans. The consequence has been a dramatic, laudable shift in how service planning is being conducted; this is evidenced in the growing number of individuals with SPMI moving from segregated settings to integrated supported housing (see discussion below relating to Sections III.I.1-2).

[4] Settlement Agreement, Section IV.A.1.b
[5] Settlement Agreement, Section II.E.1.a

This change in culture and practice can be fairly described as cutting-edge. It has required creative thought, input from a variety of stakeholders, and flexibility to change approaches midstream. While the State's efforts relating to assessment and transition planning properly remain a work in progress, the traditional "defaults," whereby individuals with SPMI were routinely placed into segregated specialized settings clearly have been supplanted by planning that is oriented towards integration.

At the same time, implementation of the Settlement Agreement over the past year has revealed a need to clarify how some provisions will be addressed if the shift toward integrated living is to be fully realized. DPC serves two different populations: individuals with SPMI who are on long-term care units and have sometimes been hospitalized for years, and individuals who are admitted for short-term acute care.[6] The IMDs, which account for the largest number of hospital admissions in the state, essentially serve the latter population. Individuals in these settings are in acute mental health crises and have lengths of stay of approximately 5-7 days.

The Monitor has found that the protocol for integrated transition planning that was developed at DPC is working well, particularly on its long-term care units. There is an increasingly collaborative (and well documented) partnership of DPC staff, community providers and the person being served to construct and implement supported housing plans. As the State's new CRISP program, which targets this population, ramps up, it is anticipated that larger numbers of individuals on the long-term care units will be moving to settings that maximize community integration.

Piloting this model within acute care settings (both at DPC and in the IMDs) has worked less well. The Monitor conducted random reviews of clinical records of individuals recently admitted to DPC for acute inpatient care. In 100% of the cases, the new protocol for transition plans based on a presumption of integrated living was completed with participation by the individual being served and the community provider. At the same time, individuals are in these settings only briefly and, given that they are in immediate psychiatric crises, they may not be in a position to meaningfully participate in person-centered planning regarding their preferred integrated setting. Although many may be desirous of and appropriate for integrated supported housing, their immediate concern is likely to be getting back home, even if that home is a non-integrated setting.

Considering all of the above, the Parties agree that requirements of the Settlement Agreement relating to transition planning and access to supported housing can be meaningfully achieved if operationalized as follows:

a. The assessment and transition planning for individuals on DPC's long term care units will continue as is.

[6] DPC also serves a forensic population, which is not being considered here.

b. For individuals receiving publicly funded acute inpatient care in DPC or an IMD, the designated community provider will take on greater responsibility for conducting and implementing a person-centered assessment, including an integrated housing assessment that is consistent with the protocol in use on DPC's long-term care units. Depending upon an individual's circumstances, this assessment may occur while the individual is hospitalized or subsequently, but in all instances the hospital record will show how, by whom and when the transition planning is to be conducted.

c. For individuals who are receiving publicly funded acute inpatient care and who lack appropriate housing upon discharge, the designated community provider will assure access to alternatives [such as "Haven Housing" (transient housing in unused group home beds) or crisis apartments] where they can live while integrated housing needs are assessed and plans are implemented.

Recommendation:

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

2. Through its system-wide QA, DSAMH should monitor discharge arrangements from acute inpatient care (both at DPC and the IMDs) to ensure that individuals are not being discharged to homelessness, shelters or unstable housing situations and that Haven Housing, crisis apartments and other arrangements are being appropriately used while permanent housing needs are evaluated and addressed.

3. Data from the QA monitoring of the use of such temporary housing arrangements should be used to inform DSAMH about the adequacy of its current capacity to prevent discharges to homelessness, shelters or other unstable living arrangements and whether additional development is needed.

4. Given the positive impact of the new transition planning protocols at DPC, both in individual service planning and in supporting a shift in culture towards an *Olmstead* orientation, DSAMH should promote the routine use of these assessments (or a variation thereof) within the community programs it funds.

IV.B.2. *Within 60 days of the signing of the agreement the State will make operational transition teams including community provider and peer representatives.*

Partial Compliance.

The Monitor's review of records within DPC and discussions with Peer Specialists and other informants confirm that transition teams are operating with participation by community providers and peer representatives. DSAMH currently monitors hospitalizations for individuals who are admitted to DPC or involuntarily admitted to IMDs. In the coming year, its oversight will be expanded to all publicly-funded individuals with SPMI who are admitted to these facilities.

Recommendation:

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

IV.B.3. *Within 60 days of the signing of the agreement the State will make operational a central specialized transition team including community provider and peer representatives.*

Substantial Compliance.

As was discussed in regard to Section IV.A, Barrier Busters was phased out as the central specialized transition team. DSAMH meets regularly with the ACT and CRISP providers to resolve problems in care. In addition, it is building on an effective model that it has devised at DPC to ensure that individuals who present challenges in discharge to an integrated setting are identified, that additional consultation is provided as needed, and that discharges to living arrangements that are not integrated are appropriately reviewed. Other than for individuals who are returning to their congregate living arrangement following brief hospitalization, DPC has initiated a special addendum to its transition planning packet (discussed above, and including participation by the individual being served and the community provider) in instances where a disposition of a non-integrated setting is being recommended. This form, in combination with other information relating to discharge planning, is the basis for reviewing either problems in implementing an appropriate plan or a proposed discharge to a setting such as a group home. It documents the types of community living arrangements that were discussed with and offered to the individual, and the reasons (including the individual's informed choice) that integrated housing is not being pursued. It specifically requires information relating to "serious

medical physical illness that requires consistent monitoring including, but not limited to: inability to ambulate, problems with other bodily functions, chronic orthostatic hypotension, brittle diabetes, wounds requiring frequent care, dementia..." that might justify a special living arrangement. The form is reviewed by a Peer, a Peer Supervisor, the Director of Professional Services and the Director of DPC before it is forwarded to the DSAMH Director and the Court Monitor. At any point, when further information or discussion is required a meeting of relevant parties can be convened. The Monitor has found that this overall process not only affords appropriate protections against the inappropriate reliance on segregated living arrangements for individuals on the long term care units of DPC, but it has also had the additional advantage of encouraging staff and other stakeholders to critically examine what had been engrained practices that are in conflict with the ADA.

As is discussed in regard to Section IV.B.1, this process will now be extended to individuals with SPMI receiving publicly-funded inpatient services at IMDs, with the designated community providers taking a prominent role.

Recommendations:

1. DSAMH should expand its QA functions to assure that transition planning in all inpatient settings occurs in compliance with the Settlement Agreement and that reviews and assistance by the centralized transition team are occurring system wide.
2. DSAMH should improve its electronic data systems to ensure that it is capturing real-time information relevant to transition planning, including such factors as individuals' living arrangements at the time of hospital admission, whether the discharge is to an integrated setting and whether reviews of discharges to non-integrated settings are taking place appropriately.

IV.B.5 *By July 1, 2012 the State shall develop a program to educate judges and law enforcement about community supports and services for individuals with mental illness on forensic status.*

Substantial Compliance.

DSAMH leadership met with all of the superior court judges and commissioners who are routinely involved with DSAMH clients at their annual retreat in April, 2012, presenting information on the ADA, the Settlement Agreement and changes underway in the service system. In June, Superior Court Judge Jan Jurden, who oversees the mental health court, hosted a meeting including the Monitor, leadership from DSAMH, legal advocates and court personnel. The intent was to review the implementation of the Settlement Agreement and its implications for the probation and diversion cases that come before

Judge Jurden's court. The meeting served as a beginning to what is expected to be an ongoing a dialogue around the factors that bring individuals with SPMI—and many with co-occurring substance abuse—into contact with the criminal justice system and how mental health programs might improve their effectiveness in averting this outcome.

V.B.4-5 *Quality Assurance and Performance Improvement: If harm occurs despite these measures, the responsible State, IMD or community provider will complete a root cause analysis within 10 days. Using the results of the root cause analysis, the State, IMD or community provider will develop and implement a corrective action to prevent future harm.*

Substantial Compliance.

At the time the Monitor's initial six-month report was being finalized, a serious event occurred at DPC, involving a patient-on-patient assault that did not result in life-threatening injuries. DSAMH had not yet completed its root cause analysis at the time the report was issued. This analysis, which was provided to the Monitor shortly thereafter, was thorough and well done. It did not identify an underlying systemic problem at DPC, and staff on the unit evidently responded quickly and competently to the resultant medical emergency.

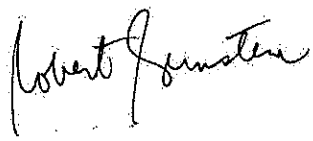
No other significant incidents of harm have been since reported at DPC or the IMDs. During the review period, DSAMH received a total of 7 reports of possible abuse, neglect or harm in community programs through the State's "PM-46" process. Three of the associated investigations determined the allegations to be unsubstantiated; the remaining four remain under investigation. All occurred in group home settings, and none involved issues of serious harm.

V. Summary

As is clearly evidenced in this report, the State of Delaware has made impressive gains over the past year, not only in achieving the specific intermediate targets required by the Settlement Agreement, but also in taking steps to establish enduring ADA-oriented practices in its service systems. Although this Settlement Agreement focuses specifically on individuals who have serious mental illnesses, the State's increasing actions to engage in implementation efforts other populations covered by the ADA (e.g., individuals with physical, developmental or intellectual disabilities) and relevant divisions of state government beyond DHSS and DSAMH demonstrates an appreciation of the importance of the ADA among Delaware's leadership.

Because of the scope of new programming and other organizational changes required in the first year of implementation, this has been a challenging period. The coming years require far less in terms of launching new types of programs, and much more in regard to refining the State's new array of services and bringing these services to full fruition. Important to this undertaking will be a continuation of the ingenuity and effort that Delaware's stakeholders have shown during the past year.

Respectfully Submitted,



Robert Bernstein, Ph.D.
Court Monitor

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Assistant Attorney General Thomas E. Perez Testifies Before the U.S. Senate Committee on Health, Education, Labor and Pensions

Washington, D.C. ~ Thursday, June 21, 2012

Good morning Chairman Harkin, Ranking Member Enzi and members of the Committee. Thank you for holding this hearing about implementation of the Supreme Court's landmark *Olmstead v. L.C* decision. The Court's ruling has often and properly been called the *Brown v. Board of Education* of the disability rights movement.

As the thirteenth anniversary of the *Olmstead* decision approaches, I am pleased to testify today about the Civil Rights Division's *Olmstead* enforcement work and about the Department's active role in ensuring that people with disabilities can realize their full potential. As you know, in *Olmstead*, the Supreme Court recognized for the first time that the civil rights of people with disabilities are violated when they are unnecessarily segregated from the rest of society. The Court's decision acknowledged that segregating individuals with disabilities in institutional settings deprives them of the opportunity to participate in their communities, interact with individuals who do not have disabilities and make their own day-to-day choices; it also recognized that unnecessary institutionalization stigmatizes people with disabilities, reinforcing misunderstanding and negative stereotypes.

The *Olmstead* decision was heralded as the impetus to finally move individuals with disabilities out of the shadows, and to facilitate their full integration into the mainstream of American life. Over the several years following the decision, through advocacy and policy and programmatic changes at the State and Federal level, there was some progress toward this goal. But the hoped-for sea change in the lives of people with disabilities has not come to fruition. More than a decade after *Olmstead*, many individuals across the country who can live in the community and want to live in the community remain unnecessarily institutionalized.

For that reason, when I became Assistant Attorney General in 2009, I identified enforcement of the *Olmstead* decision as one of the Division's top priorities. In the last three years, the Division has been involved in more than 40 matters in 25 states. We have also significantly expanded our collaborations with other federal agencies, including the Departments of Health and Human Services (HHS), Housing and Urban Development and Labor, recognizing that community integration can only be successful if people have access to necessary community services and housing. Through our *Olmstead* work, we help states comply, not only with their legal obligations under the ADA, but also with their fiscal obligations to taxpayers, by moving from expensive institutional care to more cost-effective community-based services that allow the state to leverage federal dollars most effectively. As importantly, *Olmstead* implementation serves states' broader interest in serving people with disabilities in the way most conducive to independence and full participation in community life.

The Division's *Olmstead* enforcement efforts have been driven by three goals: (1) people with disabilities should have opportunities to live life like people without disabilities; (2) people with disabilities should have opportunities for true integration, independence, recovery, choice and self-determination in all aspects of life including where they live, spend their days, work, or participate in their community; and (3) people with disabilities should receive quality services that meet their individual needs. We have learned many important lessons from the past. Chief among them is that it is not enough to move people out of institutions; we must ensure that individuals have the support and services that they need to lead successful

Attachment "C"

lives in the community.

We have used a variety of different tools in our *Olmstead*work, including reaching system-wide settlement agreements to expand community opportunities for thousands of people in several states; filing statements of interest in private litigation when questions arise regarding the ADA's legal requirements when necessary, bringing suit in court against noncompliant states and other public entities; and developing guidance documents and a website on *Olmstead*enforcement to help people understand their rights and to help public entities understand and implement their obligations. We have engaged in work on behalf of persons with a variety of disabilities, including developmental disabilities, intellectual disabilities, mental illness, and physical disabilities, and on behalf of both adults and children. This work assists people unnecessarily segregated in institutions as well as those at risk of segregation. We have challenged unlawful segregation in a wide range of settings, including state-run institutions, privately-run institutions, such as nursing homes and board and care homes, and other non-residential settings.

Matters Regarding State-run Institutions

The initial focus of our *Olmstead*work was on states that unnecessarily segregate individuals in public institutions or that place people at risk of entering public institutions. Our work focuses, not just on getting people out of these facilities, but also on the systemic reforms needed to ensure that public agencies do not put people at risk of unnecessary institutionalization.

Most recently, in Virginia we entered into a landmark settlement, to resolve the Department's finding that Virginia's system for serving people with intellectual and developmental disabilities violates the ADA by placing people in or at-risk of unnecessary institutionalization. The agreement will shift Virginia's developmental disabilities system from one heavily reliant on large, expensive, state-run institutions to one focused on safe, individualized, and cost-effective community-based services that promote integration, independence and full participation by people with disabilities in community life. The agreement expands and strengthens every aspect of the Commonwealth's system of serving people with intellectual and developmental disabilities in integrated settings, and it does so through a number of services and supports.

Among other things, the Settlement Agreement:

- Adds thousands of new Medicaid Home and Community Based Waiver slots for individuals to transition to the community from state-run and privately run institutions and for people on waitlists for community services;
- Creates a new family support program to help care for persons with disabilities in their own homes or a family members' home to prevent their unnecessary institutionalization;
- Requires the development of a comprehensive crisis system that will help divert individuals from unnecessary institutionalization;
- Provides for an integrated housing fund because we recognize that housing is a critical barrier to giving full force to the *Olmstead*decision;
- Requires the development and implementation of an Employment First Policy, prioritizing integrated, competitive-wage supported employment and the expansion of integrated employment and day activities; and
- Requires the development of a robust and comprehensive community quality assurance system.

Throughout the investigation that led to the Virginia settlement, we met with stakeholders across the Commonwealth, to learn their views about what was and was not working for people with developmental disabilities. We heard their problems and concerns, and ideas for addressing them, as well as their successes. We heard from families who were barely hanging on while their loved ones sat on long waitlists for community services and from self-advocates wanting more opportunities to work and live

independently. We also heard from the families of persons now living in institutional settings who worried whether the needs of their loved ones could ever safely be met in community settings. We took these perspectives to heart, and incorporated them into our agreement.

These stakeholder views have been shared, not only with the Department, but also with the Federal judge who is considering whether to permanently approve the agreement. In responding to the Court's invitation to submit comments on the agreement, several hundred Virginians movingly described the real-life impact of the shortcomings in the Commonwealth's current developmental disability service system, and explained why transformation of that system is so important. Some of these individuals also submitted affidavits supporting the agreement.

For example, a single mother who is caring for a pre-adolescent son with severe autism, developmental and behavioral needs, and who faces an eight-year waiting list for home and community based waiver services, told the Court that she is "overwhelmed by the thought of the years ahead" and not sure how she can continue to care for her family without the types of behavioral supports provided by the Virginia agreement. This woman wrote that receiving waiver supports would "dramatically improve" her well-being, the well-being of her son, and the well-being of his non-disabled brother. The parents of a 21-year-old with multiple disabilities who has always lived at home expressed their gratitude for recently-received waiver services that allowed them to avoid institutionalization and to continue to allow their son to "enjoy his life to the fullest." These parents urged the Court to approve the Agreement for the benefit of many other families who "desperately" need services but do not currently have them. Another parent, whose six-year-old daughter is one of approximately 7,000 individuals on a wait list for waiver services, described her joy in seeing that her child "thrives in the community" and her hope that her daughter can live in the community as an adult. She added, however, that at present, her family and many others "live in crisis" waiting for needed services.

I have also spoken with a number of parents of people living in the Commonwealth's training centers and they were very concerned, as they wondered what sort of quality control would be in place if or when their child moved into a decentralized setting in the community. I respect this concern. The *Olmstead* decision recognized that people with disabilities will move to appropriate community-based settings if they do not oppose such placement. For too long, people with disabilities have not been given meaningful choices or appropriate information to make informed choices about community services. Moving to the community will not be a realistic option for persons with disabilities if they and their families do not believe that the transition will be made in a thoughtful, respectful manner, and if they cannot feel confident that persons with disabilities will have the support needed to be safe and to thrive in the community. That is why the Virginia agreement includes a discharge planning process that includes family and community providers, and provides the opportunity to thoroughly explore community alternatives. Our consideration of the concerns expressed by family members is one of the reasons why the Virginia agreement includes enhanced protections for any person transitioning from a training center to the community.

The requirements in the Virginia agreement build and expand upon settlements we've reached in the past. For example, in October 2010, the Department, the HHS Office for Civil Rights, and Georgia reached a comprehensive, court-enforceable agreement regarding the Georgia system for serving people with developmental disabilities and mental illness. As a result of the agreement, Georgia is putting into place community-based services and supports for more than 1,000 individuals with developmental disabilities and expanding home and community-based waivers for individuals transitioning out of the State's developmental disabilities facilities and for people who are at risk of institutionalization. The State is also developing services and supports for more than 9,000 people with mental illness.

In the first year of the agreement, Georgia provided supported housing to more than 100 individuals with

mental illness, and will provide the same supports for an additional 400 individuals with mental illness this year. The State increased its existing community services to 20 Assertive Community Treatment (ACT) teams; two intensive case management teams; two community support teams; and maintained a crisis hotline, case management services, five crisis stabilization units, and peer support services. One State psychiatric hospital was closed, and the State negotiated agreements for the provision of services in community hospitals. Among the individuals who benefit from these actions is a man with a mental health diagnosis had been chronically homeless and was living in a tent. Initially, the ACT team worked with this man to find temporary housing at an extended stay hotel. Once his housing voucher was approved, the ACT team helped him search for a suitable apartment until he chose one he liked and moved in. He continues to live this stable environment.

For individuals with developmental disabilities, since signing the agreement, Georgia has ceased admissions to its State hospitals, transitioned 247 people out of these hospitals, funded an additional 100 community waivers, and created six mobile crisis teams and five crisis respite homes. The State provided family supports to 450 families of individuals with developmental disabilities this fiscal year. These changes helped a 9-year-old with developmental disabilities, who had spent her entire life living in one of the State hospitals, to move to the community. As a result of the agreement, this child is now living in a host home with a family and a nurse who is available to provide 24-hour-a-day care; in the fall, she will attend a new school where she will have the opportunity to relate to other children her age.

In July 2011, we signed a comprehensive agreement with Delaware to transform that State's mental health system. Over the next five years, Delaware will prevent unnecessary hospitalization by expanding and deepening its crisis services, including a hotline, crisis walk-in centers, mobile crisis teams, crisis apartments and short term crisis stabilization programs. Delaware will also provide community treatment teams and case management to individuals living in the community who need intensive levels of support. Our agreement also provides for scattered-site supported housing for everyone in the agreement's target population who needs it. Finally, Delaware will offer supports to enable persons with mental illness to lead integrated daily lives, including supported employment, rehabilitation services and peer and family supports. I'm pleased to report that Delaware is well on the way to meeting the agreement's July 2012 compliance benchmarks, including for crisis services, treatment, family support, supported housing and supported employment.

In a recent Delaware monitoring visit, a Civil Rights Division attorney met with several people who, as a result of the agreement, have moved from Delaware's State psychiatric hospital into their own apartments in the past year. These individuals include a formerly homeless woman; a man who had many years of involvement with the criminal justice system; and a long-term psychiatric hospital resident. Our attorney also met a 21-year old woman who, due to recently enhanced peer counseling, is now preparing to move from the State hospital to her own apartment in the community. These individuals described the positive change that our agreement had made in their lives. They said:

> "It's one more day closer to Christmas;"
> "I'm no longer invisible, people see you and say hi to you;"
> "Independence means being able to accept friendship from other people;"
> "I now have the right to just live and the freedom to open and close doors;" and
> "Thank you for giving me back my life."

There are so many other places where we are doing significant *Olmstead* work and where such work is necessary. In December 2011, we issued findings that the State of Mississippi is violating the ADA and *Olmstead* in the operation of its mental health and developmental disabilities system. We are currently negotiating with Mississippi to change its service delivery system from one that unnecessarily

institutionalizes thousands of adults and children to one that provides real opportunities to people unnecessarily institutionalized or at risk of unnecessary institutionalization. In New Hampshire, we issued findings in April 2011 that New Hampshire unnecessarily segregates individuals with mental illness in institutional settings and places individuals with mental illness living in the community at serious risk of institutionalization. We recently intervened in private *Olmstead* litigation to address these violations.

Matters Regarding Privately Owned Segregated Settings

States' *Olmstead* obligations are not limited to people who are forced to live in publicly-run institutions. As many states have been decreasing their reliance on publicly run institutions, we have seen more and more individuals with disabilities inappropriately segregated by states in privately owned or operated institutions, including nursing homes. We have been very active in *Olmstead* enforcement in this area. For example, in July 2011, the Division moved to intervene in private litigation filed on behalf of a class of approximately 4,000 individuals with developmental disabilities in or at risk of entering nursing facilities in Texas. Many of the class members had lived in the community successfully, but ended up in a nursing home because of the way the state administers its program of services for individuals with developmental disabilities.

Additionally, after a lengthy investigation of North Carolina's mental health service system, the Division issued a findings letter in July of 2011 concluding that the State is violating *Olmstead* by administering its system in a manner that unnecessarily segregates persons with mental illness in large, privately-owned adult care homes. The Department recommended that the State implement certain remedial measures, including the development of scattered site supported housing and the provision of adequate, community-based support services for people with mental illness who are unnecessarily institutionalized, or at risk of unnecessary institutionalization, in adult care homes. Currently, the Department is negotiating with North Carolina to resolve these findings.

The Division also continues its participation in *Disability Advocates, Inc.* v. *Cuomo*, a case in which a federal court in New York found, after a trial, that New York discriminates against persons with mental illness by operating its mental health service system in a manner that confines them to large, for profit adult homes, when they could and want to receive services in community settings. After the Second Circuit vacated the trial court's decision on jurisdictional grounds, the Division is considering its options for how to proceed in the case and, as with any case, seeks to resolve the case without resorting to litigation.

In other instances, we have learned of states that are segregating children in private nursing homes, depriving them of the opportunity to live with their families and in the community. In Virginia, we learned of almost 200 such children in private nursing homes and private developmental disability facilities, and our agreement provides community relief for them. We currently have an investigation in another state regarding children with physical and developmental disabilities in or at risk of entering nursing homes. We also have an open investigation into whether a state is unnecessarily placing people with physical disabilities at risk of being forced into nursing homes.

Statements of Interest

The work I have described above is in addition to the Division's participation in dozens of private lawsuits concerning the right of persons with disabilities to receive services in the most integrated setting appropriate to their needs. We have filed briefs in 27 other matters in 17 states supporting private litigation regarding people who are unjustifiably confined to institutions or at risk of being segregated in an institutional setting unnecessarily.

Guidance and Website

The Department also has developed resources to help people to understand their rights and to help states understand and implement their obligations. In June 2011, we issued the Division's first technical assistance document on *Olmstead* enforcement. In this document, we describe the requirements of the ADA's integration mandate and provide a series of questions and answers on a range of topics. Among other things, this document makes clear the Department's view that both the mandate of *Olmstead* and the appropriate remedy to unnecessary segregation apply to the full range of settings in which individuals with disabilities live, work, and receive services. We also have a website dedicated to *Olmstead* enforcement, which includes links to settlements, briefs, findings letters, and other materials.

Interagency Collaboration

In 2009, on the tenth anniversary of the *Olmstead* decision, President Obama launched the "Year of Community Living" directing all relevant federal agencies, including the Departments of Justice, Health and Human Services, and Housing and Urban Development ("HUD"), to work together to make the promise of *Olmstead* a reality for Americans with disabilities. We have embraced this directive and worked in partnership with HHS, HUD, the Department of Labor, and other agencies that have primary responsibility for programs that are essential to community integration.

We have worked with HHS, particularly the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration, to aid states in making the systemic changes necessary to provide community-based services to individuals who would be in, or at risk of, institutional placement. We have also worked with the HHS Office for Civil Rights (OCR) in matters where we have a shared enforcement interest. For example, in Georgia, the State failed to comply with a voluntary resolution agreement between OCR and the State to resolve longstanding *Olmstead* complaints and DOJ worked with OCR and the State to achieve a comprehensive, court-enforceable settlement. DOJ is currently investigating a matter in another state where OCR was unable to secure voluntary compliance. Moreover, as evident from the relief we sought in Virginia, Delaware, Georgia and other cases, we know that the lack of affordable housing is one of the biggest barriers to community living. So, we have been working with HUD to help identify for states federal resources for affordable integrated housing.

We have also collaborated with HHS and HUD on policy development, and we continue to work with HHS, including its newly-aligned Administration for Community Living, and HUD to develop and disseminate policies that can promote integration in a consistent and comprehensive way.

Ongoing and Future Work

The Department's *Olmstead* enforcement activities are dynamic and ongoing. We have several ongoing investigations, and are addressing new issues, including: the segregation of children with disabilities, people with disabilities inappropriately in nursing homes, and the segregation of people with disabilities in day-time activities, including segregated work. With regard to employment, the Division has expanded its *Olmstead* work to look beyond just where people live to examine how people live and spend their days. Simply moving someone from an institution to a community-based residence does not achieve community integration under *Olmstead* if that person is still denied meaningful integrated ways to spend their day and is denied the opportunity to do what so many people do – pursue competitive employment in the community. And so, in a federal case in Oregon, we recently filed an amicus brief supporting private plaintiffs who asserted that *Olmstead* applies to a situation in which individuals seek integrated supported employment services but are instead placed by the State in employment settings in which they have little or no opportunity to interact with non-disabled workers or to learn valuable skills that would assist them in

working in competitive employment. In addition, our settlement agreements in Virginia and Georgia require the states to expand supported employment opportunities for individuals receiving services under those agreements; and our findings letters in Mississippi and New Hampshire noted a lack of integrated day opportunities, including supported employment opportunities, for individuals receiving services in the State.

As I consider the Department's *Olmstead* accomplishments to date, and our plans for the future, I continue to take inspiration from people with disabilities, their families and their caregivers. These individuals express the harm of segregation and the value of integration more eloquently than any lawyer's brief ever could. They are the heroes of this civil rights movement. And so, I end this testimony with the words of a family member who wrote urging the Court to approve our Virginia agreement. This woman, who initially raised her son at home, very reluctantly sent him to a State institution for lack of community alternatives, and most recently has seen him make great strides upon returning to community living, told the Court:

> In my view, it is good for all of us to be able to see that people with disabilities are a part of our society and belong to us. We can respect them, admire them, interact with them, have admiration and compassion for some of the challenges they face – and we can be inspired. People with disabilities are part of us – and should not be put in isolation, unseen and unappreciated.

The Department of Justice will continue to do all we can to ensure that our *Olmstead* enforcement lives up to these words.

Thank you.