IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

UNITED STATES OF AMERICA,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 11-591-LPS
	:	
STATE OF DELAWARE,	:	
	:	
Defendant.	:	

JOINT BRIEF IN SUPPORT OF THE PARTIES' JOINT MOTION TO DISMISS

The parties jointly move the Court to enter an order to dismiss this case with prejudice because the State has substantially complied with the terms of the remedial Settlement Agreement, as described below, entered as an order of the Court on July 18, 2011. D.I. 7.

The State has implemented reforms that have transformed its service-delivery system for people with serious and persistent mental illness ("SPMI"), greatly expanded and enhanced capacity to deliver community-based services, minimized reliance on segregated institutional services, and generally improved outcomes for people with SPMI in Delaware. The State is now on a trajectory to achieve even further progress within its service system to enable people with SPMI to continue to live successfully in their homes and not subject them to unnecessary institutional segregation. To ensure sustainability of its efforts, the State recently enacted legislation that ensures the reform efforts will continue without court oversight. The independent court monitor found the State in compliance with all provisions of the Settlement Agreement, as detailed more fully in the attached Tenth Report of the Court Monitor, D.I. 182. This case is a success story.

I. BACKGROUND AND PROCEDURAL HISTORY

A. Court-Ordered Settlement Agreement

On November 9, 2010, the United States sent a Letter of Findings to Governor Jack Markell detailing systemic conditions and practices that it found violated the constitutional and statutory rights of individuals with mental illness in the State's mental health system. The United States found that the State's mental health system failed to provide services to individuals with mental illness in the most integrated setting appropriate to their needs, as required by the Americans with Disabilities Act ("ADA") and Olmstead v. L.C., 527 U.S. 581 (1999), which resulted in needless prolonged institutionalization of many individuals with disabilities in the Delaware Psychiatric Center ("DPC") who could be served in the community, and also identified numerous other deficient practices at DPC in violation of the U.S. Constitution.

The parties agreed that the ADA and Olmstead require the delivery of public services in the most integrated setting appropriate to individuals served by the State's mental health system and recognized that any remedy that focused solely on the conditions at DPC could divert resources away from building the necessary community capacity to serve Delaware citizens with mental health disabilities without unnecessary institutionalization. Therefore, the parties reached a settlement agreement ("Agreement") that focused on building community capacity and required the State to significantly expand and enhance community-based mental health services to ensure positive individual outcomes in integrated settings. D.I. 7. The Agreement emphasized the need to transition institutionalized people to the community and prevent people at risk of institutionalization from entering institutions. Id.

The Agreement specified a target date of five years for Delaware to fully implement all requirements and specified that the Court was to retain jurisdiction until the State implemented all Agreement provisions and demonstrated sustained compliance of those provisions for one

year. D.I. 7 at Section VII.A.2. On July 18, 2011, the Court entered the Agreement as an order of the Court. D.I. 7.

B. Independent Court Monitor

The Agreement provides for independent oversight and compliance reporting by a court monitor. Id. at Section VI. Robert Bernstein, Ph.D., has served in this role since the inception of the Agreement. Dr. Bernstein has conducted regular in-depth reviews of the State's mental health system, including onsite reviews at DPC, private institutions for mental disease ("IMDs"),[1] and various community providers. He has issued compliance reports twice annually, which detail the State's progress on complying with the Agreement. In his latest report, Dr. Bernstein reviewed the State's history of compliance, highlighting many areas where the State exceeded the standards set forth in the Agreement. D.I. 182, Tenth Report of the Court Monitor ("Tenth Report"). He concluded that the State has achieved substantial compliance with all provisions in the Agreement and has demonstrated a year's sustained compliance for nearly all provisions in the Agreement. Id. at ln. 257, 261-62. For the few provisions where the State has not achieved a full year of sustained compliance, Dr. Bernstein identified other assurances which demonstrate that the State's compliance will be sustained.[2]

II. INTEGRATED COMMUNITY SERVICES

The principal requirement of the Agreement is to achieve the goals of the ADA and Olmstead: to ensure that people with mental health disabilities in Delaware can live at home in their communities and avoid unnecessary segregation in institutions like DPC. The Agreement

[1] The IMDs currently serving the target population are Dover Behavioral Health, MeadowWood Behavioral Health, and Rockford Center.

[2] The State has only recently come into compliance with two provisions relating to crisis stabilization and risk management, although it earlier reached and sustained compliance with the majority of provisions related to these critical elements.

requires the State to prevent unnecessary institutionalization of individuals with SPMI by offering intensive community-based services to those individuals.[3] D.I. 7 at Section II.A. Since entry of the Agreement, the State has put in place sufficient and appropriate community-based mental health services to assist individuals with SPMI to live successfully in the community without unnecessary hospitalization at DPC. The State also has demonstrated the ability to collect relevant data, recognize key trends from the data, and respond to those trends with targeted resources. When a breakdown occurs in the State's system—an inevitability in any multifaceted organization—the State is able to quickly and appropriately respond. As a result, individuals with SPMI in Delaware are now able to live in their homes without unnecessarily entering segregated institutions, reflecting the key tenets of the ADA and Olmstead.

These systemic reforms have resulted in dramatic improvements in the lives of many individuals with SPMI. One Delawarean with SPMI, who was chronically homeless for decades, hospitalized dozens of times and diagnosed with paranoid schizophrenia, and who now lives in a supported apartment subsidized by the State, recently wrote to the United States and Dr. Bernstein:

> This letter is being typed to you to tell you how much I appreciate what you all have done to make it possible for me to live in a safe neighborhood and have my own home! . . .
>
> In my spare time I can do pretty much what I want to. . . . I don't have to worry about threats from outside sources. It is pretty quiet here, and people don't bother you. I have even chatted with the children who live at this development. They are polite and willing to communicate. . . .
>
> Well, I don't know what else to say; but I just had to thank you all from the bottom of my heart for your mercy and help.

Another Delawarean with SPMI, who grew up in the foster care system and became involved in gang activities at an early age, reported to the United States that she used to be depressed and

[3] Section II.B of the Agreement defines the population to be served, as well as specific sub-populations who are prioritized based on their elevated risk of institutional segregation. D.I. 7.

suicidal. Beginning in fifth grade, she tried to kill herself on multiple occasions and was admitted to DPC. She now receives intensive community-based mental health services from the State and especially relies on her peer support specialist to help her through difficult times. She described being "afraid of life for a long time," but now she "really believes in the State [of Delaware] and before I didn't." These individuals have made substantial progress and are now on the path to recovery.

These positive outcomes are reflected in the State's data as well. Since entry of the Agreement, the State has significantly reduced its reliance on institutional care, particularly at the state-run DPC. For instance, it has reduced the number of bed days used by the target population in DPC by 47.2% since entry of the Agreement in 2011. D.I. 182 at ln. 1230-32. These reductions have mostly occurred with regard to long-term stays (a 55.3% reduction from FY 2011), but were realized for shorter stays as well. Id. at ln. 1232-34. Additionally, the overall bed days at DPC and the private IMDs have dropped by about 26% since entry of the Agreement. Id. at ln. 1247-49. The average daily census at DPC for the target population in Fiscal Year 2016 was 76, reflecting a 42% reduction since 2010, just prior to implementation of the Agreement. Id. at ln. 1572-74. For the most part, individuals who were hospitalized in DPC at the start of the Agreement are now living successfully in the community; indeed, individuals who are receiving services under the Agreement through the State's Division of Substance Abuse and Mental Health have dramatically lower rates of hospital admissions than those who are not receiving those services. Only 9.9% of hospitalizations in Fiscal Year 2016 involved individuals receiving services under the Agreement. Id. at ln. 1387-89. Finally, the State reports that the number of Medicaid-eligible Delawareans receiving community-based services has increased by 92% since the United States began its investigation.

Despite these successes, not all of the State's data reflects perfection nor is that an

expectation of the Agreement. What makes the State's system work, however, is that the State tracks data, analyzes the data, and uses the data to drive programmatic and systemic decision-making. For instance, when the State identified increased emergency department utilization rates among people with SPMI and also saw that the overwhelming number of referrals to its mental health crisis walk-in centers (74.2%) come from emergency departments, it changed its training for emergency responders. Id. at ln. 406-17. Emergency responders are now trained to bypass emergency rooms, when appropriate, and take an individual in a mental health crisis directly to a crisis walk-in center (designed for individuals whose crisis does not require hospitalization). The State's commitment to using data to drive its decision-making strongly suggests that it is on a trajectory to sustain the progress it has made and achieve further success.

A. Delaware has a well-functioning robust crisis system

The Agreement requires the State to develop a robust mental health crisis system to respond to individuals in a mental health crisis, which the State has successfully implemented and maintained for years: it now has a crisis line for use 24 hours per day, 7 days per week; two mobile crisis teams (one in New Castle and one in Kent and Sussex Counties) that respond to a person in a mental health crisis within one hour of a call; two "living room model" crisis walk-in centers (one in New Castle and the other in Sussex County); 21 crisis apartment beds; and 3 targeted care management teams. Id. at ln. 283-85, 313-14, 431-33, 580-82, 728-29.

The State's crisis system has achieved notable success. The mobile crisis teams typically divert 80% to 90% of people they encounter from hospitalization and criminal justice interaction. Id. at ln. 388-90. The crisis walk-in center in Sussex County, which has an average length of stay of less than 23 hours, usually diverts about 70% of people from further hospitalization or criminal justice interaction. Id. at ln. 379, 390-91. The walk-in centers report that it takes law enforcement officers on average less than 10 minutes to drop-off an individual in a mental health

crisis, which motivates officers to divert individuals to a walk-in center rather than take them to an emergency room or jail, where booking is a much lengthier process.

Another important part of Delaware's crisis system is its ability to immediately link individuals who are not service connected to critical services within hours of a mental health crisis. The State has developed 3 targeted care management teams to connect individuals, many of whom are homeless, to housing, community-based mental health services, and other critical resources upon discharge from a crisis walk-in center, DPC, or IMD. Id. at ln. 728-29. To encourage a seamless transition, targeted care management teams are co-located at the crisis walk-in centers and DPC.

Despite these impressive achievements, as discussed further in Section III below, the State has not successfully reduced the number of acute in-patient bed days at the IMDs, as required by Sections III.D.3-4 of the Agreement. D.I. 7; see also D.I. 182 at ln. 517-519. As the court monitor indicated in his Tenth Report, "notwithstanding the State's success in meeting—and, in some instances, surpassing the requirements of the Agreement with regard to developing comprehensive community services, as well as its efforts . . . to address some of the structural issues affecting hospital bed use by the target population[—]realistically it would not be able to meet the targets contained in Section III.D.3-4 any time soon." D.I. 182 at ln. 552-56. It is clear from the data, court monitor's qualitative reviews, and successful outcomes for individuals, however, that the State has put in place a system that addresses the needs of people with SPMI; indeed, people with SPMI are no longer unnecessarily institutionalized in the state-run psychiatric hospital. Recognizing the overall quality of the State's service system and in reliance on the independent court monitor's recommendation that alternative measures could document the State's efforts to reduce unnecessary psychiatric hospital bed use without compromising the intent of the Agreement, the parties agreed on additional measures of compliance. Id. at ln. 560-

63, 1208. The State is now undertaking an aggressive quality assurance and improvement initiative to better understand and address factors that are contributing to the short-term psychiatric hospitalizations of people with SPMI. Id. at ln. 565-66, 1197-1201. The initial review has raised questions about whether the increased utilization even includes people with SPMI; the preliminary review showed a considerable number of misdiagnoses as SPMI when, in fact, individuals had other conditions. The State's action to address the issue, as discussed more fully below in Section III, demonstrates its continuing commitment to improving its system to further the goals of Olmstead and the ADA.

B. Delaware has exceeded the Agreement's requirements related to Assertive Community Treatment and Intensive Case Management

The Agreement required the State to create 11 Assertive Community Treatment ("ACT") teams that operate with fidelity to an evidence-based practice model, the Tool for Measurement of Assertive Community Treatment ("TMACT"),[4] and 4 intensive case management ("ICM") teams. D.I. 7 at Sections III.F, III.G. The State has exceeded and sustained compliance with these provisions of the Agreement.

In Fiscal Year 2016, the State had operational 15 ACT teams and 2 ICM teams,[5] thus exceeding the number and intensity-level of teams required by the Agreement. D.I. 182 at ln. 662-63. Collectively, these teams serve about 1,700 individuals at any given time. The ACT teams are evaluated and scored at least annually on the TMACT. Id. at ln. 675. When teams are unable to meet the TMACT requirements, the State has taken corrective actions, including, when

[4] The Agreement specifies use of the "Dartmouth Model," but early on the parties agreed that the State could use the Tool for Measurement of Assertive Community Treatment instead. D.I. 182 at ln. 625-29.

[5] With the consent of the Monitor and United States, the State converted 2 ICM teams to ACT teams in order to provide a more intensive level of service. Id. at ln. 632-34.

necessary, closing a team and transferring responsibility to another provider. Id. at ln. 675-81. The State also conducts its own quality reviews of the ACT and ICM programs, including measuring and tracking outcomes such as the average number of individuals receiving ACT or ICM services who (1) spent at least one night in a motel; (2) who were arrested; and (3) who were hospitalized in a given month. Id. at ln. 690-713.

Apart from the Agreement, Delaware also implemented the Community Reintegration Support Project ("CRISP") to provide community-based mental health services to individuals with the most difficult and complicated needs. Id. at ln. 637-40. CRISP serves 100 high-need individuals, many of whom had been long term residents or frequently readmitted to DPC, and is designed to give providers the flexibility to offer creative and individualized community mental health supports based upon the individualized needs of each individual. CRISP provider contracts are structured to incentivize positive outcomes for individuals in the community, and contain a financial incentive to avoid unnecessary hospitalization. Id. at ln. 640-45. Individuals in the CRISP program report increased satisfaction and community integration. One individual stated, "The case [managers] I have, they treat me with respect, which is something no one's ever done before." Another individual reports "doing more independent things like going to the store by myself, shopping on my own, doing grocery shopping on my own. Things like that." And others note that they are no longer in "the hospital anymore, which is a good thing" or "not in prison anymore. It helped me stay out of prison." Given that individuals receiving CRISP services, many of whom were institutionalized for years, require the highest level of care, this is truly a remarkable transformation.

Delaware engaged a team of researchers from the University of Pennsylvania, Center for Mental Health Policy and Services Research ("UPenn") to review the CRISP program. The research confirmed that "[o]verall, CRISP individuals have transitioned successfully to

community living and feel that they are part of their community." They found that individuals in the CRISP program showed increasingly positive outcomes in the community, including in domains of "control over one's life," "feelings of self-worth," and "social connectedness." DOJ Br. Number 3: CRISP, Ex. 1, at 2.

The positive results of community services created under the Agreement are felt by the individuals who receive them every day. Individuals who spent much of their lives segregated in institutional settings due to a mental health disability now report that they live at home and are sufficiently supported by their service provider. For example, one individual who lives in southern Delaware and grew up in the foster care system, described being physically abused by his father and removed from his family home when he was four years old. He has been hospitalized multiple times throughout his life for a mental health condition, spent 11 months in jail for a DUI, and periodically experienced homelessness. After the Agreement went into effect, he began to receive intensive services from a community service provider he describes as "excellent" and "focus[ed] on individuals' real needs." This Delawarean now lives in his own home, is sober, and has become involved in a peer-run drop-in center funded by the State. This is but one of many success stories made possible by Delaware's implementation of the Agreement.

C. The State has a strong permanent supported housing program

Supported housing is an important service for individuals with SPMI, who often have extensive histories of institutionalization in hospitals, criminal justice settings, or congregate mental health residential facilities and is essential to realizing the goals of the ADA and Olmstead by supporting individuals with SPMI in their own homes. Under the Agreement, the State is required to provide housing vouchers or subsidies and bridge funding to anyone in the target population who needs such support. D.I. 7 at Section II.E.2.b. The State has developed

"an impressive program that has not only met the annual targets of the Agreement's provisions, but it has also changed the service culture for individuals who have SPMI and with respect to the requirements of Olmstead." D.I. 182 at ln. 935-37. Delaware has created a system that makes integrated housing the "default." The State prioritizes individuals' housing preferences and preferred living arrangements, rather than simply "slotting" them into an available spot. As a result, housing stability has increased year-over-year since implementation of the Agreement such that individuals are remaining permanently housed for longer periods of time. Id. at ln. 929-32. Further, the State funded 812 permanent supportive housing vouchers in Fiscal Year 2016, exceeding the Agreement's targets. Id. at ln. 879. While there are some individuals on the waitlist for housing, the State has appropriately identified individuals in need of housing and its waitlist is moving at a reasonable pace, consistent with the requirements of Olmstead. Id. at ln. 898-903.

D. Delaware has a growing workforce of individuals in the target population

The State has provided supported employment services to thousands of individuals with SPMI in the target population, meeting the requirements of the Agreement. D.I. 7 at Section III.J; D.I. 182 at 978-79. Although the percentage of people in the target population who are employed is 15%, the State continues to expand work opportunities for people with disabilities. Id. at ln. 996. The number of people in the target population who are employed has increased four-fold since Fiscal Year 2014, suggesting that the State's efforts and prioritization of supported employment are paying off. Id. at ln. 992-93. Additionally, the State actively funds and supports other meaningful day activities for individuals with SPMI, including through the Creative Vision Factory in downtown Wilmington, a peer-run art studio that supports recovery through the arts, and the ACE Center in Seaford, a peer-run drop-in center that focuses on fellowship and well-being. Id. at ln. 1047-49.

E. The State provides family and peer supports to the target population

The Agreement requires Delaware to provide family or peer supports to a total of 1,000 individuals. D.I. 7 at Section III.L. Delaware has exceeded this target in more ways than one. Delaware reports 2,383 average monthly peer contacts in Fiscal Year 2016. D.I. 182 at ln. 1063. The majority of those contacts occur within ICM or ACT teams, not including other contacts individuals may have at peer-run drop-in centers like the Creative Vision Factory or ACE Center. Id. at ln. 1063.

Even more importantly, however, Delaware has fully integrated peers into its delivery of mental health services, both inpatient and in the community: peers orient individuals upon their admission to DPC, assist them during the course of their hospitalization, and provide personal care items upon discharge to the community; operate drop-in centers;[6] conduct quality reviews of ICM and CRISP services; and are essential members of ACT, ICM, CRISP, crisis apartment, and crisis walk-in center teams. Id. at ln. 1042-49. Delaware also has a peer program that specifically serves individuals with SPMI or co-occurring disorders in the State's Mental Health Court. Id. at ln. 1068-69. Mental Health Court Peers provide support to individuals as they proceed through diversion or probation and assist peer defendants to access resources in the community such as housing and transportation. In June 2016, there were 52 Mental Health Court peer contacts.

What is difficult to measure, but nevertheless apparent, is Delaware's achievement in creating a mental health system in which peers feel welcomed and supported in their work. Delaware embedded these values into every aspect of its system, including provider contracts.

[6] The State funds the ACE Center in Seaford, the Creative Vision Factory in Wilmington, and the Rick Van Story Center in Wilmington. These peer-run organizations are essential components of Delaware's mental health system. The State has made a commitment to ensuring that these programs are appropriately funded and supported long after the Agreement.

For example, the CRISP contract states that peers "shall be received and treated as a meaningful addition to the agency's workforce and integrated into the philosophy and service system for their unique and valuable strengths and perspective." App. A-1 Division Requirements for Behavioral Health Service Providers, Ex. 2, at Section E.i. It also specifies that "[p]eers are not to be used as 'add-on' staff, substitute staff, or volunteer labor except in time limited and very goal oriented projects." Id. The State has worked to ensure that peers are critical members of mental health service delivery in Delaware. Peer inclusion is a major shift in the way Delaware has supported community integration in the wake of the Agreement and Delaware has taken important steps to ensure that peer supports outlast the Agreement. See Infra., Section V.

III. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Prompted by the Agreement, Delaware established a robust quality assurance and performance improvement system ("QA/PI"). D.I. 182 at ln. 1137-41. The QA/PI system is intended to ensure that services are of appropriate quality and are achieving the goals of the ADA and Olmstead: community integration, independence, and self-determination. As part of the QA/PI system, the State created a "Quality Control Steering Committee" that is charged with monitoring compliance related to the provision of mental health treatment and wraparound services:

> The Committee is responsible for analyzing, interpreting, and acting on data related to specific performance measures in an effort to identify where systems: experience failures or weaknesses, demonstrate opportunities for improvement and/or require corrective action.
>
> The use of data to drive [the State's] quality control initiatives is part of Delaware's Olmstead plan to ensure that individuals with disabilities are not unnecessarily hospitalized for mental health treatment when community-based services would be appropriate. The State believes strongly in the rights of Delawareans with disabilities to live independently and to exercise meaningful self-determination and choice in their treatment as well as all aspects of their lives. [The State] will use data to inform its decision making regarding utilization of services, quality of care, and overall functioning of Delaware's public mental health system to sustain evidence-based decision making that is consistent with the requirements of Olmstead.

DSAMH Steering Committee: Quality Control Initiatives, Ex. 3, at 1. Currently, the Steering Committee is charged with addressing the increased utilization of acute in-patient hospital beds, among several other initiatives. The State has been collecting and analyzing a comprehensive set of measures that reflect hospital use, diversion activities, and measures to address critical risk factors for hospitalization. D.I. 182 at ln. 1208. By examining this data, the State is seeking to better understand and address factors that contribute to the acute psychiatric hospitalization of the target population, as well as factors that obscure its measurement of services, outcomes, and needs of people with SPMI (such as misdiagnosis). This effort has culminated in several on-going quality assurance activities:

1. Establishing a High-end User Review Committee that will identify clients who are frequently admitted to inpatient facilities and will ensure that those clients identified as high-end users are linked with the appropriate level of services. Ex. 3, at 4-5.

2. Identifying clients who are homeless at the time of admission to an IMD to ensure that all clients who present as homeless at the time of admission are referred for housing placement. Ex. 3, at 9.

3. Investigating how homelessness affects lengths of stay among members of the target population who were hospitalized at DPC. Ex. 3, at 11.

4. Holding monthly QA/PI meetings between DSAMH and the IMDs to resolve problems in care, including coordination and information sharing between hospital and community providers. Ex. 3, at 16.

5. Conducting an investigation with the University of Pennsylvania of the needs of individuals living in community housing who have complex challenges, particularly with respect to addressing Activities of Daily Living. Ex. 3, at 18-19.

6. Ensuring that a collaborative process is in place to assess the housing needs of all clients who are transitioning to a community setting. Ex. 3, at 25.

The State has also identified several other quality assurance activities that will support its continuing efforts to improve its system:

1. Ensuring that the Quality Process Review ("QPR") function[7] is fully integrated into the

[7] Through the Quality Process Review, an average of 330 recipients of ACT and ICM services are interviewed each year.

DSAMH Quality Control processes and that the QPR analytical data reports are included in the formal reports submitted to the DSAMH Steering Committee. Ex. 3, at 6.

2. Studying the rates of court commitment for inpatient or outpatient treatment. Ex. 3, at 13.

3. Ensuring that client death review investigation occur for deaths of clients receiving the most intensive services: ACT, ICM, and CRISP. Ex. 3, at 20.

4. Conducting an initiative to incorporate into practice data from the evaluation of the CRISP program that reflects the ongoing partnership between the State and the University of Pennsylvania. Ex. 3, at 18.

The sophistication of the State's QA/PI process improved substantially in the last rating period, but the State has demonstrated throughout the course of the Agreement a commitment to using data to inform its decision-making: when ICM was ineffective for some members of the target population, the State converted 2 ICM teams to ACT teams; when the rates of emergency department utilization increased, the State trained its emergency responders on the availability of crisis walk-in centers; when the crisis center in New Castle County was less effective than the center in Sussex County, the State built a new center in New Castle County that is modeled after the Sussex County one. D.I. 182 at ln. 136-39, 382-84, 632-34. Further, as described below in Section V, the State has taken several other important steps to ensure that QA/PI remains an essential component of its mental health system.

IV. RISK MANAGEMENT

The Agreement requires the State to establish a risk management system that provides a clear mechanism for integrated analysis of risk. Recently, the State established "a central clearinghouse where analyses of risks and adverse events affecting the target population [can] occur with the collective involvement of all responsible agencies and through which patterns of risk could be identified and addressed systematically." D.I. 182 at ln. 1652-54. Through memoranda of understanding, the State now ensures that the Division of Medicaid & Medical Assistance, Division of Long Term Care Residents Protection, Division of Substance Abuse and

Mental Health, and Department of Public Health share information about risk management. Id. at ln. 1655-57. The State is also convening incident review meetings where risk management information relating to the target population is being consolidated and discussed with multi-agency input. Id. at ln. 1657-59. Although this is a new system and the State has not demonstrated substantial compliance for a full year, as Dr. Bernstein concluded, the State has ensured long-term sustainability of the program by embedding risk management into recently enacted legislation. See Infra., Section V.

V. SUSTAINABILITY OF REFORMS

Delaware's commitment to the principles of Olmstead and sustaining the reforms that it has made to its mental health system is further exemplified by passage of key legislation, implementation of a new Medicaid program, and creation of a peer-directed grievance process.

A. Legislation

Delaware achieved three separate legislative reforms of its mental health system within the five-year period of the Agreement. In the most recent legislative session, the Delaware General Assembly passed SB 245 to establish an independent oversight commission to monitor Delaware's public mental health system. Id. at ln. 177-82. The Commission will be appointed by the Governor and include a variety of stakeholders, from doctors to peers, and will be supported by the Delaware Department of Justice. It ensures that a community of stakeholders has access to Delaware's critical incident reports and will hold the State accountable for the mental health services it provides and systems it oversees. The conduct and records of a specialized Peer Review Subcommittee, established within the Commission, are subject to Delaware's peer review privilege to ensure the Commission's ability to engage in critical analysis of State and provider operations and outcomes in an open, frank, and robust manner. The Peer Review Subcommittee is required to have at least two public meetings per year as well

as provide an annual report to the General Assembly. This report guarantees that the Commission's work and recommendations are made public for further review and consideration.

Recognizing that civil commitment is often the entry point to hospitalization, Delaware has twice modified its statute governing civil commitment to provide for greater procedural protections and to imbue the process with the tenets of Olmstead's integration mandate. In 2012, the General Assembly passed HB 311, which restructured the initial 24-hour emergency detention period, the first step in the civil commitment process in Delaware. Id. at ln. 161-66. HB 311 dictated that a 24-hour emergency detention could no longer occur in an emergency department, and instead had to take place in a specialized mental health crisis center or psychiatric hospital. HB 311 also created a new crisis screening position designed to address the overuse of emergency detentions by those who lack specialized crisis training or knowledge of available community resources. The goal of HB 311 was to reduce reliance on civil commitment as a way to "clear" emergency departments and compel providers to seek the least restrictive means to assist a person in crisis.

HB 311 was followed two years later by HB 346, which addressed the parts of the civil commitment process that occur after the initial 24-hour emergency detention. Id. at ln. 172-76. HB 346 revised the criteria for both probable cause hearings and civil commitment hearings to require proof of a direct link between a mental health condition and an imminent threat of dangerousness, as well as showing that inpatient hospitalization is the least restrictive placement for an individual. The law also reduced various timeframes in the civil commitment process and created a number of new procedural requirements designed to protect individuals agreeing to voluntary treatment who might not otherwise fully understand the implications of a voluntary admission. HB 346 established for the first time in Delaware specific and distinct criteria for outpatient commitment.

As a result of HB 311 and HB 346, Delaware has realized reductions in both inpatient and outpatient commitments. Between Fiscal Year 2011 and Fiscal Year 2016, inpatient commitments decreased by 6.1%[8] and outpatient commitments decreased by 63.3%. Id. at ln. 1545-47, 1563-64.

B. Medicaid Promoting Optimal Mental Health for Individuals through Supports and Empowerment ("PROMISE") Program

In addition to legislative changes, Delaware has also significantly enhanced the availability and delivery of community mental health services in the State since the implementation of the Agreement by making structural changes to its Medicaid program. By capitalizing on the federal-state Medicaid partnership, Delaware is now able to provide services in a way that is financially sustainable for the State.

In 2014, the State received approval from the Centers for Medicare and Medicaid Services to create the PROMISE program to serve individuals with SPMI who are the target population of the Agreement. PROMISE provides benefits counseling; case management; community-based residential alternative supports that exclude assisted living; community transition services; community psychiatric supportive treatment and other services by non-licensed clinical staff including evidence-based practices, such as ACT and ICM; financial coaching; non-medical transportation; nursing; peer supports; personal care; respite; skill-building for individual activities of daily living/chore; and supported employment. Id. at ln. 195-211. As of August 2016, the majority of the contracts necessary for full enactment of PROMISE

[8] Between Fiscal Year 2011 and Fiscal Year 2014, inpatient commitment decreased by 41%; however, there was a notable uptick in inpatient commitments between Fiscal Year 2015 and Fiscal Year 2016. DSAMH is currently reviewing possible reasons for the increase inpatient commitments. Id. at ln. 1562-66.

benefits have been completed and implementation is underway.[9] To date, the State reports that there are approximately 2,175 individuals receiving services through PROMISE. Of those, 1,381 are Medicaid beneficiaries and 794 have their services paid for solely by the State. Notably, only about 10% of individuals receiving PROMISE services were hospitalized in Fiscal Years 2015 and 2016 and those individuals reflected only 10% of total hospital admissions for those years. Id. at ln. 1391. The PROMISE program has dramatically expanded the reach of community mental health services in Delaware to low-income individuals with SPMI. It is an important sustainability effort that allows Delaware to leverage federal dollars through Medicaid to provide an expanded array of community mental health services and supports that previously were either unavailable or solely state-funded.

C. Community Grievance Process

The Agreement does not require the availability of a grievance process for individuals receiving mental health services in the community; however, for the past several years, Delaware has been working closely with advocacy groups and peers to enhance its community grievance process. This effort has resulted in the creation of a toll-free hotline, and most recently, a dedicated email account. Individuals also have the option to file a grievance directly with the DSAMH Director or Director of Community Services at any time.

A full time employee with DSAMH's Quality Assurance Unit receives and responds to incoming grievances. These are then documented, allowing DSAMH to analyze complaints and grievances by provider, program, and county. After the initial communication from the individual reporting the grievance, the employee emails the individual's provider using a standardized correspondence template with a summary of the individual's concerns. DSAMH

[9] The only outstanding contracts are for nursing services, personal care services, and financial counseling.

asks for the provider's input as well as for information on whether and how the concerns have been previously addressed. DSAMH also gives the provider a deadline for responding that is tailored to the severity of the grievance and consistent with applicable federal and state regulations. This email is copied to the PROMISE Clinical Services Administrator for the county in which the individual resides. The relevant parties create and implement a person-centered, recovery-oriented resolution, with the individual at the helm of the process. The resolution process includes confirming with the individual that the matter had been resolved from their point of view and that the relevant parties followed through on the deliverables for resolution. Once the grievance is resolved to the individual's satisfaction, DSAMH sends the individual a standardized letter summarizing the reported grievance and the outcome.

Based on input from the peer community, DSAMH is in discussions to train peers in the community on the grievance process and how to help individuals file a grievance. Likewise, DSAMH is also exploring the use of PROMISE case managers to assist with grievances as well. The hope is that peer support will empower individuals to raise concerns about their care directly to DSAMH by further facilitating a grievance process that is distinct from an individual's provider.

DSAMH has fostered a more proactive and comprehensive community grievance process because it is an important tool for individuals to advocate for themselves and it also facilitates direct communication between individuals and the State about the services provided. Delaware has transformed its mental healthcare system into a person-centered model that encourages individuals to advocate for themselves, point out perceived problems, and demand accountability.

VI. CONCLUSION

As detailed in this brief and in the Monitor's Tenth Report, D.I. 182, the State has

achieved substantial compliance with the terms of the remedial Settlement Agreement entered as an order of the Court. D.I. 7. Accordingly, the Parties respectfully urge the Court to dismiss this case with prejudice, and to cancel the scheduled October 13, 2016, oral argument.

Respectfully submitted,

FOR THE UNITED STATES
PLAINTIFF:

VANITA GUPTA
Principal Deputy Assistant Attorney General

EVE L. HILL
Deputy Assistant Attorney General

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

MARY R. BOHAN
Deputy Chief
Special Litigation Section

Date: October 6, 2016

/s/ Elizabeth C. Kelley
Elizabeth C. Kelley [VA Bar #80255]
Trial Attorney
United States Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, N.W.
Patrick Henry Building, Room 5427-B
Washington, DC 20530
Telephone: (202) 514-0460
Fax: (202) 514-0210
Beth.Kelley@usdoj.gov

FOR THE STATE OF DELAWARE DEFENDANTS:

STATE OF DELAWARE
DEPARTMENT OF JUSTICE

DATE: October 6, 2016

/s/ Aaron R. Goldstein
Aaron R. Goldstein (#3735)
State Solicitor
Carvel State Office Building, 6th Fl.
820 North French Street
Wilmington, Delaware 19801
(302) 577-8400

DATE: October 6, 2016

/s/ Sarah Fishman Goncher
Sarah Fishman Goncher (# 5481)
Deputy Attorney General
Health Law Unit, Unit Head
Carvel State Office Building, 6th Fl.
820 North French Street
Wilmington, Delaware 19801
(302) 577-8188

CERTIFICATE OF SERVICE

The undersigned certifies that on October 6, 2016, she caused the attached *Joint Brief in Support of the Parties' Joint Motion to Dismiss* to be filed with the Court via CM/ECF and served electronically to the following:

Aaron R. Goldstein
Sarah Fishman Goncher
Delaware Department of Justice
Carvel State Office Building, 6th Fl.
820 North French Street
Wilmington, Delaware 19801

UNITED STATES
DEPARTMENT OF JUSTICE

/s/ Elizabeth C. Kelley
Elizabeth C. Kelley (VA Bar #80255)